Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12:04 p M 2011 Fernandez Lemieux Beatriz December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's 23085 Green Holly Road Lexington Park 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Days Hours (Month, Day, Year) 07/29/1918 Philippines Director 213-13-4164 93 Usual Residence of Decedent or 28a-f shov notified at show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland St. Mary's Lexington Park 10e. Street and Number items 23a or ner must be n 10f. Zip Code 10g. Citizen of What Country? Funeral 23085 Green Holly Road 20653 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ō Completed by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced "natural" Asian other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) 6 <u>Homemaker</u> Own Home permit. Page 1 and 2 should be filed Department of Health and Mental Hy, Important: If item 27 is marked other any injury or other traumair. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Anastasia Maglente Cipriano Albao 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23085 Green Holly Rd., Lexington Park, MD 20653 Zenaida A. Altherr/Daughter 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of 1 X Burial 2 Cremation 3 Removal from State Immaculate Heart of Mary 4 ☐ Donation 5 ☐ Other (Specify) 12/28/2011 Lexington Park, MD 21. Signature of Funeral Service oc. se Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A.
41590 Fenwick St., Leonardtown, MD 20650 Tickaet 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus Onset and Death Immediate Cause (Final -Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury signed by the attending physician and defeated for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☒ No Dav Year g to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2 🗌 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 10 Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of s after death. 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident filled in by the Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nyrse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

3 eme

Michael S. Szkotnicki, M.D.

31. Date filed (Month, Day, Year)

DEC 2 8 2011

e and address of person who complete

37 Registrar's Signature

cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

22590 Shady Court, California, MD 20619

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month obert 1255 Lowr Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anundel Medical Center Anne Mnapoli Anundel 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Dav. Year) 577-36-6844 Hours Director 1 🛚 M 2 🗆 F 82 August 23,1929Washington, D.C. permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 X No Maryland Anne Arundel Lothian 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 55 Edward Lane 20711 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces?
1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Vending Vendor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert B. Lowry Irma Simpson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula DeRosa / Daughter 30417 Jay Avenue, Salisbury. Maryland 21804 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Dongtion 5 Other (Specify) Kalas Crematory 12-13-2011 Edgewater, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home of Funeral Service Licenses 2973 Solomons Island Rd., Edgewater, MD 21037 also 23a. Part 1. Iter the disease, shock, r heart failure. Lis complications It caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? signed by the a 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 🖼 No 3 ☐ Probabiy 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Director: After this certificate I 1 Tes 2 No Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work?
1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier 🕻 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Profesia 2001 Medical MO Annapolis DEC 1 32 Registrar's Signature State 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #5 per FD AACO Health Dept. 12-20-11 KAH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 12 Physician/ OBERT Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Harwood Mandrin Hospice House 9. Birthplace (State or Foreign 5. Secial Security Number 577-16-7461 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Months Barramore, MD 09/YY4/IY9<u>Y</u>2O 91 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10b. County 10c. City, Town or Location Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State Director 1 🗆 Yes 2 🔀 No Annapolis MD Anne Arundel 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the 10e. Street and Number Funeral USA 21401 927 Mastline Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Specify: Completed 3 Widowed 4 Divorced Year or Dates. WWI] 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Retail Owner Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Toube London 2 Meyer Lerner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Annapolis, MD 21401 927 Mastline Drive Lillian F. Lerner Spouse 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Mount Lebanon Cem 12/12/2011 Adelphi,MD 4 Donation 5 Other (Specify) 21. Signature of Fyral Service Li 22. Name and Address of Facility 12 Ridgely Ave Annapolis, MD 21401 Hardesty Funeral Home P.A. Day 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ -D10m disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) Yes 2 No 1 Yes 2 L 9 Unknown ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? certificate has been signed rector, page 2 should be def To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: 1 ☐ Yes 2 ☐ No 1 Yes 2 Th 26. Place of Death (Check only one) 25. Was case referred to medical OSPICE 1 ☐ Yes 2 💢 No 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral directors. 28a. Date of injury (Month, Day, Year) House 28b. Time of 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29d. Date signed (Month) 29b. Signatura and tit

State Registrar Date filed (Month)

eted cause of death (Item 23a) (Type, Print)

istrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene

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	To the within To the comple	2	29b. Signature and title of certi	ier				c. License		217			ate signed			,
•			30. Name and address of person	m who completed cause of	death (Item	n 23a) (T vp e.	Print)	Y.	47	212		n N	1	01	201	/
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	Sta Registr		31. Date filed (Month, Day, Year	5 2011 32. Pegist	rar's Signa	ture										

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 12 Physician/ 5:00 AM MarkAnthony Vivar McKinzie Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death **Examiner** lisbure Wicomic tospice at the If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Hours 606-30-2298 1**X** M 2 □ F Director Yrs. 02/28/1989 Phillipines 22 Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10c. City, Town or Location 10a. State items 23a or 28a-f sho ner must be notified at **Funeral Director** 1X Yes 2 ☐ No Pocomoke City MD Worcester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe USA 21851 2613 Cambrook Dr. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Force Black, White, etc. ō 1 X Never Married 2 Married Completed by ☐ Yes 2**X** No 1 ☐ Yes 2X No If Yes, Give ^{Specify:} White 3 Widowed 4 Divorced Year or Dates. the Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) Education Student Learning of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, the once. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Mercedita Vivar permit. Page 1 and 2 should be Department of Health and Ments Larry McKinzie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2613 Cambrook Dr., Pocomoke City, MD, 21851 Mercedita Yaeger/Mother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State First Bapt. Ch. Cem. 12/20/2011 Pocomoke City, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Holloway Funeral Home P.A. 21. Signature of Funeral Service Licenses 107 Vine St., Pocomoke City, MD, 21851 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Other (specify) Pregnant at time of death 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 certificate has performed 1 ☐ Yes 2 ☑ No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ည this funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: eral Director: After filled in by the funer work?
1 Yes 2 No 5 🗌 Pending 1 Natural Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

within 24 hours after death. To the Funeral Director: Al To the Hospital

person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Centifying Nurse Practitioner of the best of my hours of the cause stated.

29d. Datersigned (Month, Day, Year)

29c. License number

State

(Check

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Robert Charles Moore Sr. 2011 11 <u>December</u> 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death <u>Annapolis</u> Anne Arundel Anne Arundel Medical Center Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Days Hours 412-28-9092 1 💢 M 2 🗆 F Ohio 88 Jul. 3, 1923 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Gambrills 1X Yes 2 No Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 1718 Mayapple Way 21054 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces? 1 X Yes 2 No 1942 Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 √ No Specify. If Yes Give White 3 Widowed 4 Divorced 1969 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Government <u>Budget Analyst</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Effie Burke Charles Moore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1718 Mayapple Way, Gambrills, MD 21054 Ann Moore - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 😾 Cremation 3 \square Removal from State 4 \square Donation 5 \square Other (Specify) Metro Crematory 12-14-2011 Baltimore, MD of Funeral Service Licencee 22. Name and Address of Facility Beall Funeral Home MOLINU MD 20715 6512 NW Crain Hwy Bowie.

Physician/ Medical Examiner

> burial-trar physician

For State Registrar

MD

Physician/

Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Important: If it any injury or o

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examine Be Completed by Physician/Medical ပ Medical Certificate: n 24 hours after death.

e Funeral Director: Ai pletely filled in by the fu

29a. Certifie

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To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

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	23a, Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused the deat cause on each line.	h. Do not enter the mo	de of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	resulting in death)	Due to (or a consequ	uence of):	/			
	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ience oij.				
	that initiated events resulting in death) Last	Due to (or as a consequ	uence of):				
1	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregna 1 Live Birth 2 Fets 4 Pregnant at time of a 9 Unknown	al death 3 🗌 Ectopic			23d. Date of de Month	elivery Day Year
	Part II. Other significant conditions cont	ributing to death but not res	sulting in the underlying	g cause given in Part I.			o the cause of death? Probably 4 Unknown
					24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
	25. Was case referred to medical			26. Place of Death (Che	ck only one)		
	examiner? 1 Yes 2 No	spital: 1 Inpatient 2	ER/Outpatient 3 🗆	Other: 4 Nursing H	lome 5 🗆 Residence	6 Other (Spe	cify)
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year) 28b. Time of injury work? 1 Yes 2 No 28d. Describe how injury work? 1 Yes 2 No						ury occurred	
3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Rose City or Town, State)						ural Route Number,	

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 06-2011

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State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 10:15PM 2011 Ethel Sergeon Martin Dec Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 13022 Ingleside Drive Beltsville Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs, last birthday) Funeral 1 □ M 2 🕱 F Min. 6-8-1921 90 Director 225 14 5219 Usual Residence of Decedent 10d. Inside City Limits , or items 23a or 28a-f show aminer must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Xyes 2 No Prince George's Beltsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 13022 Ingleside Drive 20705 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black White etc. 1 Never Married 2 Married Yes 2 KNo þ Baltimore, Maryland 21215-0036 1 ☐ Yes ∠ If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: Black "natural" Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done of life, DO NOT use retired) (Specify only highest grade completed) during most of working permit. Page 1 and 2 should be filed within 7, Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event the Max College (1-4 or 5+) Elementary/Seconday (0-12) School Teacher Government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bledsoe Sergeon Nora Yancy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Tammye Martin Fall/ Daughter 8402 Kittama Dr.Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Danville Mem.Cem. 12/17/2011 Danville, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Briscoe-Tonic Funeral Home 21. Signature of Funeral Service Licensee 2294 Old Washington Rd. Waldorf, MD 20601 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Alzheimer's Dementia years disease or condition resulting in death) Medical Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and deelached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 - Fetal death in the past 12 months? Dav Pregnant at time of death 2 🔀 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? this certificate has performed 1 Yes 2 No 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2X No ည 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at After work? 5 Pending 1 Yes 2 No Investigation ☐ Accident within 24 hours after death

To the Funeral Director: A 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title MD036716 12/14/2011

State Registrar Mikhail

31. Date filed (Month, Day, Year)

DEC

DHMH 17 Rev 7/2009

32. Registrar's Signature

2150 Pennsylvania Ave NW Washington, DC 20037

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Koqan, M.D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1010AM Delores Jean Morris December 28,201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington Hagerstown Meritus Medical Center Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F 06/27/1929 Director 216-22-8091 MD Usual Residence of Decede 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland must be notified at Director Washington Hancock 1 X Yes 2 No 5 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 23a Funeral 21750 USA 103 Washington Street 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. th and Mental Hygiene. 27 is marked other than "natural", or iter traumatic event, the Medical Examiner Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Completed White 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Resturant 8 Waitress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Mable Suella Shoemaker Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 250 West Main Street Hancock, MD 21750 Sharon S.Hendershot/Neice other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5 Department of Important: If any injury or once. 12/31/2011 Hagerstown, MD Cedar Lawn Mem.Park 21. Signature of Juneral Service Licensee 22. Name and Address of Facility 141 West Main Street MOO260 Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final CVA Onset and Death Pnysician/ disease or condition resulting in death) Cosi LEFT dear Medical Due to (or as a consequence of) Examiner OLD NOI SURT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or linjury sician and burial-transit DEPENDENT DIABBIER NSULIN MELLITU Re that initiated events resulting in death) Last the attending physician ched for use as the burial Physician/Medical 1RB HUPBRIENSIDW Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending phys IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Day Year Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Whiknown Completed DISABILITY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an FUNCTIONAL autopsy performed' 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) ည Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be filled in by the 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Now D0072433 2011 an 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

JAN 0 5 2012

Noor Siddigui, M.D. 324 E. Antietam St., Suite 305 Hagerstown, MD 21740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) December 8. Physician/ 2011 11:10 AM Terry Devon Newman Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Prince George's Clinton Southern Maryland Hospital 9. Birthplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 230-17-8031 35 06/09/1976 1 X XM 2 | F Director Vashington, DC Usual Residence of Decedent 10d. Inside City Limits ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10a. State 10b. County Director xxxes 2 □ No Washington, DC 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 20032 3955 Martin Luther King Avenue S.W. death \ "natural", or items edical Examiner mu 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Black White, etc. Armed Forces 1 X Never Married 2 Married Yes 2XXNo permit. Page 1 and 2 should be filed within 72 hours after i Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin þ Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2xx No Specify: If Yes Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4 or 5+) Handicapped Disabled Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carol Α. Brown Sylvester C. Newman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3955 Martin Luther King Ave. S.W. Wash., DC 20032 Sherrie Worthy 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kalas Crematory Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial **XX** Cremation 3 ☐ Removal from State Edgewater, Maryland 12/18/2011 4 Donation 5 Other (Specify) Signature of Juneral Service Ligensee 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final FNCEPHALOPATH) Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause Er to the cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death 1 ☐ Yes ∠ ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? DISORDER 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy death? 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28c. Injury at work? 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D52900

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MUSA MOMOH MD 12150 ANNAPPUS ROAD #205, GLENN DAVE MD

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State

Registrar

DEC 1 3 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42510 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ KENNETH K NG 0603AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Pmnapolis, Maryland mundel Medical Center Anne trundel County 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 579-64-5173 Director 1 X M 2 🗆 F Jan. 7, 1949 China Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland **Funeral Director** notified 1 Yes 2 No Maryland Anne Arundel Crofton 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? must be 23a 21114 USA 2483 Vineyard Lane items (Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item edical Examiner r 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed Chinese permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natun any injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Graphic Arts Designer Printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Yee Choe Ng Siu Yuen Wong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald W. Routzahn/Personal Reb. 1128 Bragers Road Odenton, MD 21113 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Cremtory 12/13/2011 Glen Burnie, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ LVer tailure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner metastatic Canter Sequentially list conditions, if any leading to immediate Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury as the burial-trar that initiated events Due to (or as a consequence of) the attending physician Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the burn of the funeral director, page 2 should be detached for use as the burn. Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Fetal dea ☐ Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To 1 Nnpatient 2 🗆 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at work? 1 Yes 2 No 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Example 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 10 101 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 Medical Parkway Annapolis MD Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 RTCHARD EUGENE December 1:26 AM Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, July 11 Funeral 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 X M 2 D F Days South Carolina **Director** 78 247-52-8113 1933 July Usual Residence of Decedent 28a-f show 10a. State Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 8103 Runnymeade Drive 21702 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 🔀 Yes 2 🗌 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 9 ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify. Specify: White "natural", Completed 3 Widowed 4 Divorced Year or Dates. 1952-56 or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. Telecommunications Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Garvin Owens Sarah Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 and 2 s Health 8103 Runnymeade Drive, Frederick, Maryland 21702 Lepartment of Healt Important: If item 2, any injury Patricia Owens / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Olivet Cemetery | 12/16/2011 Frederick, Maryland. Signature of Funeral Service Licenses 22. Name and Address of Facility
Stauffer Funeral Homes P. A.
1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Anoxic disease or condition days Medical resulting in death) Examiner ESPIRATORY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) ASPIRATION andtran Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant a
9 Unknown 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year 2 No ed by the a 1 ☐ Yes 2 ☐ Unknown cate has been signed l page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed Yes 2 No 1 Yes 2 No Division of Vital Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) 1 Natural 5 Pending 24 hours after death.
Funeral Director: Aft leted filled in by the fur 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: Je the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Warse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health, and Mental Hygiene 2 1- State of Maryland / Department of Health, and Mental Hygiene 2 1- State of Maryland / Department of Health, and Mental Hygiene 2 1- State of Maryland / Department of Health, and Mental Hygiene 2 1- State of Maryland / Department of Health, and Mental Hygiene 2 1- State of Maryland / Department of Health, and Mental Hygiene 2 1- State of Maryland / Department of Health, and Mental Hygiene 2 1- State of Maryland / Department of Health, and Mental Hygiene 2 1- State of Maryland / Department of Health, and Mental Hygiene 2 1- State of Maryland / Department of Health, and Mental Hygiene 2 1- State of Maryland / Department of Health, and Mental Hygiene 2 1- State of Maryland / Department of Health, and Mental Hygiene 2 1- State of Maryland / Department of Health, and Mental Hygiene 2 1- State of Maryland / Department of Health, and Mental Hygiene 2 1- State of Maryland / Department of Health, and Mental Hygiene 2 1- State of Maryland / Department of Health Agent / Department of Health Agent / Department of Health / Department / Dep 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2011 Physician/ O'MALLEY JOSEPH **JAMES** DECLEMBER Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** CHAR CETUTE MEDICAL Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 6. Sex **Funeral** Days Hours 184-12-0151 1 🗽 M 2 🗆 F Director OCT.24,1923 PENNSYLVANIA 88 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State with the Maryland notified at Director 1 Yes 2X No 28a-f WASHOE RENO NV 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ŏ ms 23a or must be r Funeral 89511 U. S. A. 17095 CASTLE PINE "natural", or items? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. D'MALLEY, JOSEPH þ 1 Never Married 2 Married 1 Yes If Yes, Give 2**X** XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE Completed 3 Widowed 4 X Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natun any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) **5 +** Elementary/Secondary (0-12) LAW FIRM ATTORNEY Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MARY CATHERINE MORAN ပ္ EDWARD L. O'MALLEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 13900 LULLABY RD., GERMANTOWN, MD 20874 PATRICIA O'MALLEY/DAUGHTER 20b. Place of Disposition (Name of 20c. Location - City or Town, State DECEMBER 20a. Method of Disposition ST. MARY'S CH. CEM. 29, 2011 Burial 2 Cremation 3 Removal from State BRYANTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. 21. Signature of Funeral Service Lice M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 V 24 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Aspiration Physician/ disease or condition resulting in death) Medical Due to for as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tra that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Division of Vital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 1 XInpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 27. Manner of Death Certificate: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation completely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of symmination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 [To the I within 2 only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of January 5, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAMAD MEDICAL ENTER - WISTA filed (Month, Day, Year) PLATA, MD 20646

State

Registrar

JAN 0 5 2012

47

Barka

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Robert Charles Powel1 8:30 December 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Ouantico 25765 Pemberton Drive Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** (Month, Dav. Year) Days Hours 222-16-6098 Director 1 X M 2 🗆 F ខា Delaware 07/17/1930 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10a. State death with the Maryland must be notified at Director 1 Tes 2 X No Maryland Wicomico Ouantico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö Funeral items 23a 21856 25765 Pemberton Drive USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Examiner Armed Forces?

1 Yes 2 No Black, White, etc. or þ 1 Never Married 2 X Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Completed White of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Mechanic Farming Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Grace Marie Morris Charles Robert Powell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25765 Pemberton Dr., Quantico, MD 21856 Barbara Powell/Spouse 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date Department of I-Important: If ite any injury or ot cemetery, crematory or other place Springhill Memory Gardens 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 12/20/2011 Hebron, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22 Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ans Medical to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Liner Underlying Cause (Disease or injury Due to (or as a consequence of) use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 D Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ detached for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown filled in by the funeral director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed?

1 Yes 2 No 1 🗌 Yes 2 🗆 No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 24 hours after death. Property Air Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie within 24 hor To the Fune completely f (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Sidnature and ti d cause of death (Item 23a) (Type, Print)

Registrar

1. Date filed (Month, Day,

Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 8:50 18 2011 Sharon Fitch Peters December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Sharpsburg 5647 Mondell Road If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day Nov. 11 9. Birthplace (State or Foreign Social Security Number . Age (In yrs. last birthday) **Funeral** 1943 New York 1 M 2 X F Months 68 Director 310-44-4128 Usual Residence of Decedent show 10d. Inside City Limits 10a, State 10c. City, Town or Location within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified 1 ☐ Yes 2 X No Maryland | Washington Sharpsburg 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21782 5647 Mondell Road items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Examiner Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. 1 Never Married 2 K Married "natural", or Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. White 3 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mea Elementary/Seconday (0-12) College (1-4 or 5+) Church Ordained Presbyterian Minister Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Irene May Holaday Ephraim Schley Fitch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sharpsburg, Maryland 21782 5647 Mondell Road David H. Peters / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-22-2011 Keedysville, Maryland Fairview Cemetery 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA Signature of Fu Boonsboro, MD 21713 7606 Old National Pike hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1 Enter the disease, or complications shoot, or heart failure. List only one caus Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death Pregnant at time of death Day in the past 12 months?
1 Yes 2 No Month Year 1 ☐ Yes ≥ L Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autonsy death? 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 은 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) and title of certifie 29c. License numbe 29b. Signature 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

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State

Registrar

31. Date filed (Month

gistrar's Signature

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Physician/ 3 2011 13:34p Pinkney Joyce Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George Southern Maryland Hospital <u>Clinton</u> Birthplace (State or Foreign Country) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday, Funeral Months Hours Director 150-32-5886 1 🗆 M 2 🔀 F Maryland 8-11-40 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State Examiner must be notified at Director 1 XYes 2 No Maryland Prince George Upper Marlboro 10g. Citizen of What Country? 10e. Street and Number ò Funeral 2077.2 USA 13005 Van Brady Rd items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. id Mental Hygiene, marked other than "natural", or i þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: If Yes, Give Black Completed 3X Widowed 4 ☐ Divorced other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Prince George Bd College (1-4 or 5+) Elementary/Secondary (0-12) of Education Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Young Lelia Bullock permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11605 Assisi St. Upper Marlboro MD 20772 Rosalind Pinkney/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Date X Burial 2 ☐ Cremation 3 ☐ Removal from State Upper Marlboro MD 12-21-11 Nottingham-Myers 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 20608 Home Pa, Aquasco MD Adams Funeral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final SEPSIS Physician/ disease or condition resulting in death) Medical Examiner JELMONIA Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to for as a consequence on Cause (Disease or injury attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No Day Pregnant at time of death g Unknown been signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? SCLERODERMA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔽 Unknown Division of Vital Records, HYPERTENSION PULMONARY 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has I performed? Yes 2 N 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medica Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🛂 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death. Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident filled in by the 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0064986 2/14/2011

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

19 2011

32. Registrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Plea	ise Type or	Print in	Black Ir	ndelibl	e Ink	. Ens	ure A	III Copie	s Are	Leg	ible.		
		_ For	State of	Marylan	id / Depa	artment	of H	ealth a	and N	/lental Hy	giene				
		- State Registrar			Cer	tificate	of D	eath			Reg. No.	20		425	16
		1. Decedent's Name (First, Middle	e, Last)							2. Date of De	ath			3. Time of Dea	ath
Physicia		Louis	R.			Proc	tor			Month 12	Day 1 2	'	Year 11	10:25	\mathbf{a}^{M}
Medic Examin		4a. Facility Name (if not institution		per)		4b. City, T			of Death	12			of Death	110.23	u
7	•	3428 William	chura Dr			Waldorf					C	har	-100		
Funeral		5. Social Security Number		7. Age (In yrs. I	ast birthday)	If Under 1 Year If Under 24 Hrs. 8. Date of B									reign
Director		218-30-3330	1 X M 2 □ F		Yrs.	Months	Days	Hours	Min.	(Month, Da					
- M		Usual Residence of Decedent		79						11-20-	<u>-193</u>	2		yland	
yland f sho	tor	10a. State 10b. County		10c. Cit	y, Town or Lo	cation								10d. Inside City Li	
Mar 28a- otifie	Director	Maryland Char	les	Wa	aldor:	E								1 X Yes 2	∐ No
h the		10e. Street and Number				10f. Zip	Code				10g. Citi	zen of V	What Coul	ntry?	
h wit ns 23 nust	Funeral	3428 William						601				SA		* <u>_</u>	
deat iten ner r		11. Marital Status	12. Was Deced Armed Ford	ces?						ecify Yes or No- Rican, etc.)			e - Americ	can Indian, etc	
after [", or xami	l by	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	ried 1 XYes If Yes, Give	^{2 □ No} 19!	55 .	1 ☐ Yes 2	₩ No	Specify:					Bla		
ours atura	Completed		Year or Dat nt's Education	es. 19!	57 L										
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ould Me mar		19a. Informant's Name/Relations	hin (Type Print)	Proc	ctor	a Addross	(Ctroot or		ssie	al Route Numbe	e Cityon	Town S			1
2 shith ar th ar 27 is trau						-					_		-		
and Heal tern		Irma Proctor 20a. Method of Disposition	- wile	20b. F	13428 Place of Dispo			sour		or, Wal				own, State	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2 Cremation		State	cemetery, crer	natory or oti	her place								
urtme artme ortan injury		4 Donation 5 Other (\$ 21. Signature of Funeral Service I		Re	surre	CT1C Name and				7-11	CII	nto	n, MI)	
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		shock, or heart failure. List of Immediate Cause (Final			, /	\sim			Cardiac 1	or respiratory at	1031,			Approximate Interval Betwee Onset and Deal	
Physician/ Medical		disease or condition resulting in death)	a	OLON		-AN	CER							Oriset and Dear	
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ath certificate be executed attending physician and for use as the burial-transit	a	,	L												
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ath c atten for u	cial	in the past 12 months?		Birth 2 Feta		Ectopic p		,			'		nth	Day Year	
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deat deat ctor: y the	≝	2 ☐ Accident Investi 3 ☐ Suicide 6 ☐ Could	not be	of Injury - At he	ome farm str			res Z L	INO	29f Location /	Ctmot one	- Alumb	or or Pum	J Route Number.	
or A after Direct	Çe	4 ∐ Homicide detern		g, etc. (Specif)		cci, ractory,	OHIGO			City or Tov			er or nura	noute Number,	
spital cours reral	g	29a, Certifier . 1 Certifying	Physician: To the be	est of my know	rledge death	occurred at	the time	date and	nlace a	nd due to the c	ause(s) ar	nd manı	ner as stat	terl	
To the Hospital or Attending Phystcian: The law requires that the death certificate be within 24 hours after death. To the Luneral Director. After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the bu	Medical	(Check 2 🔲 Medical I	xaminer: On the basi Nurse Practitioner:	s of examinatio	n and/or inves	tigation, in n	ny opinior	n, death oc	ccurred a	t the time, date a	and place,	and du	e to the ca	ause(s) and manne	er stated.
orthin orthin comp	2	only one) 3 L Certifying 29b. Signature and title of certifie		to the best of t	iny knowledge	200	Licence	numbor		T				Day, Year)	
-> - 0		h.14	MA				1) (7201	85		10	1,	21.	2	
افار		30. Name and address of person		of death (ton	n 23a\ (Time	P#nt)		^			(*	- (2/	2011	20
30		So. Name and address of person	AMAN A		501 .	SURR	977	5 R	OAG	# 30:	7 (un	vton	M) 20:	135
Stat	e	31. Date filed (Month, Day, Year)	32 %	gistrar's Signa	iture	,	, , ,		الحرا ا	11					
Registra		DEC 16	ZUIT	I KING I	A. 19	arked	ie.								

			. For						nd Mental Hyg	_			
			State Registrar			Cer	tificate of l	Death		Reg. No. 201	1 42517		
⊎ Phy	sician	1/	1. Decedent's Name (First, Middl						2. Date of Dea Month	Day Ye			
4 Kilon	ledica amine	_	Thomas Crockett 4a. Facility Name (if not institution				4b. City, Town, o	r Location of E	December Death	4c. County of E	5:15 A M		
	amme		10945 Lawrence	Drive			Waldor			Charles	,		
	eral	- 1	5. Social Security Number	6. Sex 7. A	ge (In yrs. las	st birthday)	(y) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 9. Birthplace (State or Fo						
Dire			235-34-8724 Usual Residence of Decedent	1 X M 2 □ F	85	Yrs.			March 27	7, 1926 We	est Virginia		
yland f sho	ed at	햦	10a. State 10b. County	/	10c. City,	Town or Lo	cation				10d. Inside City Limits		
e Mar	notifi	ě	Maryland Charle	es	Wa	ldorf	10f. Zip Code		1	10g. Citizen of What	Y Yes 2 No		
with th	ed tst	Funeral Director	10945 Lawrence	Drive			20603			USA	. Oddini y 7		
death	ler m	ᆵ	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S.	13. V		lispanic Origin an, Mexican, P	? (Specify Yes or No- ruerto Rican, etc.)	14. Race - A	merican Indian, /hite, etc.		
36 after al", or	b b b b b b b b b b b b b b b b b b b				☐ Yes 2X☐ No		, ,		White				
21215-0036 within 72 hours after giene.	To a. State 10b. County 10c. City, Town or Location 10d. City or Ind. Company 10d. City, Town or Location 10d. City or Ind. Company 10d. City, Town or Location 10d. City or Ind. Company 10d. City or Ind							ess/Industry					
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rlan d be fill dental	tic ev	പ	Charlie Everett	·					e Rose Bea	,			
Maryland 2 should be filed the and Mental Hy 27 is marked oth	ranma		19a. Informant's Name/Relations	ship (Type, Print)				and Number o	or Rural Route Number	r, City or Town, State,	Zip Code)		
e, N and 2 Health	ther t		Pat Presley/ So 20a. Method of Disposition	on			Mark Dr	ive, Wa	ldorf, MD	20601 20c. Location - City	or Town State		
Baltimore, Dermit. Page 1 and Department of Hea Important: If item	yoro		1 ☐ Burial 2 🂢 Cremation 4 ☐ Donation 5 ☐ Other (3 Removal from State	e ce	metery, cren	natory or other plan Crematory			Clan Ri	unio		
altii rmit. P partm portar	any injur	ŀ	21. Signature of Funeral Service	* **	ncia			ss of Facility	ec. 11, 201 Huntt Fune	<u>u Maryia</u> eral Home	and		
m 225	E G	4	*Kelli N			9931	035 01d V	<u>Vashing</u>	ton Rd. Wa	aldorf, MD	20601		
Physic			23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition			Po not ente	the mode of dyir	ng, such as car	rdiac or respiratory arm	est,	Approximate Interval Between Onset and Death		
Med Exam	_		resulting in death)	Due to (or as	s a conseque	ince of):	and me	4	lisese				
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			UE ECHANIE.	d									
X 68 th cert	or use		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal	death 3	Ectopic pregnan	су		23d. Date of Month	delivery Day Year		
Box ne death of the atten	ched t) Sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ∐ Pregnant 9 ☐ Unknowr	at time of de	ath 5∟	Other (specify) _			Worth	Day fear		
es that the dea signed by the a			Part II. Other significant condition	1	but not resul	lting in the u	nderlying cause gi	ven in Part I.	23e. Did to	bacco use contribut	e to the cause of death?		
ords, requires been sig	g pinc	led :	Cardion	myo pat	ny				1 🗆 ነ	Yes 2□No 3□	Probably 4 Unknown		
COF law re	e z sh	Completed by		() 0	1				24a. Was a autop	osy prior	autopsy findings available to completion of cause of		
Vital Reconvision: The law in certificate has be	r, pag		05.14							rmed death 2 No 1	Yes 2 No		
/ital	directo	0 Pe	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	tient 2 🗆 E	P/Outpation	_ Oth	er:	Check only one)	lana 6 🗆 Othor (C			
n of Vital Records, ding Physician: The law requires h. After this certificate has been signal.	neral		27. Manner of Death 1 Natural 5 ☐ Pendi	28a. Date of in	jury 2	28b. Time of injury	28c. Injur	y at		ow injury occurred	оеспуу		
ion tendir death. tor: Af	the tu	Certificate:		igation			M 1 🗆	Yes 2 No					
Division of Vital Records, P.O. Box 6876 to the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy			4 Homicide determ	mined 28e. Place of Ir	ijury - At hom tc. <i>(Specify)</i>	ne, tarm, stre	et, factory, office		28f. Location (S City or Town		Rural Route Number,		
Hosp 24 ho	letely i	Medical	(Check 2 Medical I	g Physician: To the best of Examiner: On the basis of g Nurse Practitioner: To the g Nurse Practitioner: To the best of g Nurse Practitioner: To the g Nurse Practitioner: To the	examination a	and/or invest	igation, in my opini	on, death occur	rred at the time, date ar	nd place, and due to t	he cause(s) and manner stated.		
To the Hospital within 24 hours To the Funeral C	dwoo		29b. Signature and title of certifie		no best of filly	. In ownedge,	29c. Licens			29d. Date signed (Mo			
			Mink	avuil M	0		Doc	6165	52	12/10	2011.		
	<u>_</u>	Į.											
80	0		30. Name and address of person	who completed cause of	las l	23a) (Type, P	Post 0	This	Rd. Wa	aldos	MD. 20603		

11-09593 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Leah Marie Phillips State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day December 21, 2011 **Medical Examiner** 1606 hrs Leah Marie Phillips 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Union Hospital 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Davs Hours Director Months 1 M 2 X F Country) 212-85-8738 Yrs 4/16/2009 MD Usual Residence of Decedent iny 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Impurtant: If item 27 is marked other than "natural", nr items 23a or 28a-f shu iujury are rather traumatic event, the Medical Examiner must be notified at ouce. Ceci1 E1kton Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 412 North Street USA Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married White etc. 2 X No Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: White 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 N/A N/A - Child 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Daniel Phillips Amy Combs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amy Combs - mother 412 North Street, Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State North East Cemetery 12/29/2011 4 Donation 5 Other Specify: North East, MD 22. Name and Address of Facility 21. Si of Funer R.T. Foard Funeral Home, PA 259 E. Main Street, Elkton, MD 21921 ort I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval Between Onset and ilure. List only one cause on each line /Medical Death a Infective Pericarditis complicating Sepsis Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Ca X UNPENDED AMENDED 23a, 27, per me, g925 3-8-12 sm attending physician or use as the burial Vital Records, P.O. Box 68760 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death Live birth 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 ✔ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has b autopsy performed? 1 ✓ Yes 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) funeral director, examiner? Hospital: 1 / Inpatient 2 Other Nursing Home 5 Residence 6 Other ER/Outpatient 3 DOA this 1 🗸 Yes ö After 28a. Date of Injury (Month, Day,Yeer) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural Division 5 Pending 1 Yes 2 No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined Homicide

Hospital nr Attending Physician: filled in by the To the Hospital nr At within 24 hours after d. To the Funeral Direct completely

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s).

and manner stated

Assistant Medical Examiner

32. Registrags Signature

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifie

Zabiullah Ali, M.D.

31. Date filed (Month, Day, 140) 5 20

2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

December 22, 2011

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Dep	artment of Health a		7111	42519
		Registrar 1. Decedent's Name (First, Middle, Last)	tilicate of Death_	2. Date of Dea	Reg. No. San	3. Time of Death
Physici		Karolyn Louise Rauen		Month Decembe	Day Year	11:40 PM
Med Exami		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of		4c. County of Death	
<i>₹</i>		St. Mary's Nursing Center	Leonardtown		St. Mar	
Funera Directo	_	5. Social Security Number 6. Sex 1 M 2 K F 7. Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under Months Days Hours	24 Hrs. 8. Date of Birtl Min. (Month, Day April 5	Year) 1930 Neb	hplace (State or Foreign Intry) raska
		Usual Residence of Decedent		1,191223	2,35 3,55	
yland -f sho ed at	ctor	10a. State 10b. County 10c. City, Town or Lo				10d. Inside City Limits 1 ☐ Yes 2 🙀 No
e Mau r 28a notifi	Dire	Maryland St. Mary's Califor	nia 10f, Zip Code		10g, Citizen of What Co	
with th	Funeral Director	44087 Redbud Lane	20619		United Sta	tes
death items ier mu	E	Armed Forces?	Was Decedent of Hispanic Original Mexican		14. Race - Amer Black, White	
after after xamir	d by	1 Never Married 2 X Married 1 Yes 2 X No	1 ☐ Yes 2 🛣 No Specify:		Specify: Whi	
hours hours natura ical E	Completed	15. Decedent's Education 16a. Dece	dent's Usual Occupation	A. C. contitue	16b. Kind of Business	Industry
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d with lygien ther the	Be C	4 Teac		er's Name (First, Middle,	Education	
and antal H ced of	P B	17. Father's Name (First, Middle, Last) Kenneth Lowell Nelsen	Loui		waiden Sumame)	
aryl nould l s marl umati		19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mail	ing Address (Street and Number	er or Rural Route Numbe	r, City or Town, State, Zip	o Code)
, Missing and 2 strains and 27 is no 27 is er trains	1	Theodore James Rauen-Spouse 4408	7 Redbud Lane,	California		
Ore letar Tof He riter		20a. Method of Disposition 1	ematory or other place)	Date	20c. Location - City or	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at		4 Donation 5 Other (Specify) Brinsfil		12/19/2011		
Depart Depart any is		Kathleen A. Santivasci- MO0872 B	22. Name and Address of Facility rinsfield Fune	ral Home PA	Marylan	Leonardtown nd 20650
		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	4	cardiac or respiratory an	rest,	Approximate Interval Between Onset and Death
Physician Medica			eumonia			Onset and Death
Examine	_	Due to (*r as a consequence of):				
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50 te be executed nysician and ne burial-transit		resulting in death) Last Due to (or as a consequence of):				
760 cate b physi	edical	d				
certific	an/N	IF FEMALE: 23c. If yes, outcome of pregnancy 1	☐ Ectopic pregnancy		23d. Date of de	
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me		Other (specify)		Month	Day Year
P.O. that the ned by 1	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part	1. 23e. Did to	obacco use contribute to	the cause of death?
ds, quires en sign				1 🗆	Yes 2 Mo 3 □ P	Probably 4 🗌 Unknown
Records, The law requires ate has been sig	Completed			24a. Was auto	psy prior to	topsy findings available completion of cause of
Rec The la cate hig				1 🗆 Yes	ormed? death? 2 No 1 Yes	s 2 No
f Vital Re Physician: The this certificate ral director, pag) Be	25. Was case referred to medical examiner? 1	Othori	ath (Check only one) Jursing Home 5 Residual	danca 6 Other (Spec	nifu)
in of Viding Phy th. After this funeral d	te: To	27. Many r of Death 28a. Date of injury 28b. Time			now injury occurred	
sion ttendin death. stor: Aft y the fur	fical	2 Accident Investigation	M 1 ☐ Yes 2 ☐			
Division of Vital tal or Attending Physician: ts after death. al Director. After this certific ed in by the funeral director.	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (City or Tox	Street and Number or Ru vn, State)	ıral Route Number,
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director. Af	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	n occured at the time, date and	place, and due to the ca	ause(s) and manner as st	ated.
the Ho nin 24 the Fu	Med	(Check only one) 2 ☐ Medical Examiner: On the basis of examination and/or inversion only one) 3 ☐ Certifying Nurse Practioner: To the basis of my knowledge	, death occurred at the time, dat	te and place, and due to the	ne cause(s) and manner as	s stated.
viti Do		29b. Signature and title of certifier	29c. License number	100	29d. Date signed (Mont	n, Day, Year)
		30. Name and address of person who completed gause of death (Item 23a) (Type	Print		1911	1 1
DRMe		2007 Tidemoter Colony Drive		Anapoli	s, MD 21	801
	tate	31. Date filed (Month, Day, Year) DEC 2 0 2011 32. Fegistrar's dignature	back			
Regis	urar	OFO WALLET	<i>y</i>			

42520

hysician		Registrar					rtificate o	Dealli		ne	g. No.		
yerelan		1. Decedent's Name (First,		,				·_·_		Date of Death Month	Day	Year	3. Time of [
/Medical		James		odore		≥11, S	1			December	20,	2011	10:42
xaminer	r ²	4a. Facility Name (If not ins			ber)		4b. City, Town					unty of Death	_
		St. Mary 5. Social Security Number	y's Ho		. Age (In yrs.	In me to look to also al	Lec	onardto		8. Date of Birth	S	t. Mar	
ector		579-56-8968 Usual Residence of Deced	1	1 X M 2 F	69	Yrs.	Months Day		Min.	(Month, Day, 02/08/1		9. Birth	place (State or ntry) Mary1
any Injury or other traumatic event, the Medical Exprimer must be notified at once. To Be Completed by Funeral Director	- 1-	10a. State 10b. C			10c. Cit	y, Town or Lo	ocation					1	10d. Inside City
oto lo		Maryland	St. M	lary's		Bushwo	ood						1 ☐ Yes
Director	5 2	10e. Street and Number					10f. Zip Code	е		10	g. Citizen	of What Cou	ntry?
12	la l	21238 Whit	e Nec					618				SA	
by Funeral	un la	11. Marital Status 1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 ☒ Div		12. Was Deceded Armed Force 1 Yes 2 If Yes, Give Year or Date	es? ŒNo		Was Decedent of If Yes, specify C 1 ☐ Yes 2 X N			cify Yes or No- Rican, etc.)		Race - Ameri Black, White, ecify:	
ted	9	15. De	cedent's Ed	ducation		16a. Dece	dent's Usual Occ	cupation		10	6b. Kind o	of Business/In	
Completed	E -	(Specify only Elementary/Secondary (highest gra	ade completed) College (1-4	lor 5+)	(Give	kind of work dor DO NOT use ret	ne durina mos	st of workin	ng			,
Ö	5	10	, , , ,			Comme	rcial S	eafood	Harv	ester	S	eafood	
Be		17. Father's Name (First, N						18. Moth	er's Name	(First, Middle, Ma	aiden Suri	name)	
ြို		Charles	Henr	ry Rus	sell			Fr	ances	s Myr	t1e	Ower	ıs
		19a. Informant's Name/Rel	, ,			1	-			l Route Number,	•		o Code)
L	-	James T. Ru	issel	L, II/Sor						Maryland			
		20a. Method of Disposition 1 🛣 Burial 2 □ Crem 4 □ Donation 5 □ Ot	her (Specif	(y)	ate i		osition (Name of matory or other p Memorial					on - City or To ardtown	
N N N N N N N N N N N N N N N N N N N	:	21. Signature of Funeral Se	ervice Licer	Hard	iner) 2	Name and Add Matting 41590 Fe	ress of Facili Ley-Gai enwick	rdine St.,	r Funera Leonard	1 Ho	me, P. , MD 2	A. 0650
in al		23a. Part 1 Enter the disea shock, or heart failure Immediate Cause (Final disease or condition resulting in death)	ise, or come. List only	a	h line.		ter the mode of d				st,		Approximate Interval Betw Onset and D
r				Due to (or	as a consequ	ience or):		/					
ner .		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	J	b. Due to (or	ava consequ	uence of):	Heart	For	lun		_		Your
al Examiner	LAGIIIII	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1	c	as a consequ	uence of):	leart	Fai	Yun				Year
	LAGIIIII	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	{	c	as a consequ	uence of):	leart	Fai	Yun				Your
/Medical	miculcal Evaluation	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregna in the past 12 months' 1 □ Yes 2 □ No	nt \	c	as a consequence of pregnath 2 Fetal nt at time of de	uence of): uence of): ncy death 3 [Ectopic pregna	incy	lun		23d.	Date of delive	ery Day Ye
by Physician/Medical	ay in your and the second and the se	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregna in the past 12 months'	nt ?	C. Due to (or d	as a consequence of pregna the 2 Fetal nt at time of divin	ncy death 3 [eath 5 [☐ Ectopic pregna	incy		23e. Did toba	ecco use o	Month	Day Ye
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 10 Physician/ Month Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washinston Glen Burnie Hone Social Security Number **Funeral** Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) 11/24/193 Min 1 XX 2 - F 118-24-9844 **Director** 80 Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified 1 Yes 2XXNo MD Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 476 Rita Dr. 21113 USA iral", or items? 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by Yes 2 No If Yes, Give 1 Never Married 2 Married 1969 Baltimore, Maryland 21215-0036 White 1 ☐ Yes XX No Specify Specify "natural", 3 Widowed 4 ☐ Divorced Year or Dates 1981 the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done duning most of working life. DO NOT use retired) (Specify only highest grade completed) if Health and Mental Hygiene.
item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Owner/Operator Service Station Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Herman Roberts Clara Franz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Roberts Daughter 308E Gatehouse Lane Odenton, MD 21113 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) - F of 1 🖈 Burial 2 🗆 Cremation 3 🗆 Removal from State Department of Important: If any injury or Meadowridge Cemetery 12/13/2011 4 Donation 5 Other (Specify) Elkridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Dav Pregnant at time of death 2 No 1 L Yes 2 L 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: မ 1 Department 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 29d. Date signed (Month. Dav. Year. Name and addre of person who completed cause of death (Item 23a) (Type, Print) Olen SW 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar	State of Maryla		artment of tificate of			liene Reg. No. 20		42522
			Decedent's Name (First, Middle, Last)					2. Date of Dear	th	V	3. Time of Death
	Physicia Medic		William H	unter Re	ams			Decemb	ser 21,	2011	0305 M
}	Examin		4a. Facility Name (if not institution, give stre	et and number)		4b. City, Town, o	or Location of Death		4c. County	of Death	
مممد			Meritus Medical C		I - A h i - th ol - i - t	Hage If Under 1 Year	rstown I If Under 24 Hrs.	8. Date of Birth		shing	ace (State or Foreign
	Funeral Director			7. Age (<i>In yr</i> s. 72 72	Yrs.	Months Days		Month, Day Dec. 17	Year) 1939	Flor	ida
	, wc	. h	Usual Residence of Decedent		* T					10	d. Inside City Limits
	nyland I-f sh ied at	Director	10a. State 10b. County		ity, Town or Loc					1	1 Yes 2 X No
	or 28¢		Maryland Washington 10e. Street and Number	n l	Keedys	10f. Zip Code			10g. Citizen of V	Vhat Count	ry?
	with t	Funeral	19120 Geeting Road			2	1756		U.S.A	. •	
	death items		11. Marital Status	. Was Decedent Ever in L Armed Forces?	I.S. 13. V	Vas Decedent of f Yes, specify Cub	Hispanic Origin? (Spoan, Mexican, Puerto	pecify Yes or No- p Rican, etc.)		e - America k, White, e	
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any righty or other traumatic event, the Medical Examiner must be notified at once.	d by	1 ☐ Never Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 💢 No If Yes, Give	1	☐ Yes 2 🛛 N	o Specify:		Specify:		
9	hours natura lical E	Completed	3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Busine								
215	in 72 ie. han "ı e Med	dmo	(Specify only highest grade Elementary/Seconday (0-12)	College (1-4 or 5+)	life. De	O NOT use retired		Kirig			. 1
121	d with Hygier ther t	on t	17. Father's Name (First, Middle, Last)	4	Mech	anical E	1	ne (First, Middle, I	U.S. G		ment
Maryland 21215-0036	be file ental P ked o ic eve	To		eams			Bernadi		_	een	
ary	hould and Mi s mar		19a. Informant's Name/Relationship (Type,	Print)	19b. Mailir	ng Address (Stree	t and Number or Ru			tate, Zip C	ode)
Σ	nd 2 s ealth a m 27 i		Gail L. Reams / wi				g Road K				
ore	tof H for H if itel or oth		20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3 ☐ Re		Place of Dispo cemetery, cren	sition (Name of natory or other pla	i	Date	20c. Location -		
Baltimore,	it. Pag irtmen irtant: njury	1	4 Donation 5 Other (Specify)	St		Cremato	ry 12-2 ress of FacilityBas	2-2011			
Ba	Deper Impo		21. Signature of Funeral Service Jacob See	(el)			National				21713
		П	23a. Part 1 Enter the disease, or comple shock, or heart failure. List only one	at ons that caused the de ause on each line.	ath. Do not ente	er the mode of dy	ing, such as cardiac	or respiratory arr	est,		Approximate Interval Between
	Physician/		Immediate Cause (Final disease or condition		cirrh					317	Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a conse	quence of):		11.04.004				Iweoks
	350	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	quence of):	price	umon	W.			10006
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease Or imjury that initiated events c.								
	ate be executed physician and the burial-transit	aj Ex	resulting in death) Last	Due to (or as a conse	quence of):						
200	physic the bi	edical	d.								
189	certific nding use as	N/U	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of preg	nancy	7 5			23d. Da	te of delive	ery
Box 687	requires that the death certifica been signed by the attending p should be detached for use as t	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth 2 Fe 4 Pregnant at time of g Unknown		Other (specify)			Mo	onth	Day Year
P.O. I	at the of	Phy	g Unknown Part II. Other significant conditions cont		esulting in the I	ınderlying cause	given in Part I.	23e Did to	phacco use cont	ribute to th	e cause of death?
٠ <u>.</u>	res that signed	Completed by	Tartin Street digitalisation contains contains			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					pably 4 🛣 Unknown
ord	requi been should	lete						24a, Was			osy findings available
Seco	he law te has age 2	dwo						autop perfo 1 Yes	rmed?	prior to coi death? 1 🔲 Yes	mpletion of cause of
al F	ian: T rtifica rtor, p	Be C	25. Was case referred to medical examiner?			26.	Place of Death (Che				
Ž	hysic his ce	은	1 ☐ Yes 2 🕅 No	spital: 1 Inpatient 2		nt 3 🗆 DQA		Home 5 Resid)
n of	ding P. h. After t funera	ate:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of injury (Month, Day, Year)	28b. Time o injury	wo	ury at ork? ⊒Yes 2□No	28d. Describe h	ow injury occurr	ea	
Division of Vital Records,	Attender deat	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At	home, farm, str				Street and Numb	er or Rural	Route Number,
Divi	s afte			building, etc. (Spec				City or Tow			
	To the Hospital or Attending Physician: The law requires that the death certifics within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as to	Medical	Check 2 Medical Examine	an: To the best of my kno	tion and/or inves	stigation, in my opi	nion, death occurred	at the time, date a	ind place, and du	e to the cal	use(s) and manner stated.
	o the	ž	only one) 3 Certifying Nurse 29b. Signature and title of certifier	Practioner: To the best of	my knowledge,	death occurred at	the time, date and pl nse number	ace, and due to the	e cause(s) and m 29d. Date signe	anner as st	ated.
	17		Manjon J	naj		D2	8365		12-21	1-11	
U	-		30. Name and address of person who con		em 23a) (Type,	Print\					
	10			SHAM.		nul 2	stral-	14 agen	Hour	MA	21740
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's Sig	B. 4	ale					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 42523 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Rasberry Frances Patricia December 12:15 Medical 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Washington Hagerstown Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 💢 F Months (Month, Day, March 1 Days Hours Director 341-01-0488 96 Iowa Usual Residence of Decedent show 10a. State 10b. County death with the Maryland be notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f 1 Yes 2 X No Maryland Washington Boonsboro ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 6127 Mary Ann Court 21713 U.S.A. items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give 0 Black White etc 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2X No Specify. "natural" Completed 3 Widowed 4 X Divorced Specify. Year or Dates White Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha 12 Escrow Clerk Financial Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Lyle Kincaid Pauline Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i of Health Patricia N. Smith/daughter 6127 Mary Ann Court Boonsboro, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Stauffer Crematory 12-21-2011 Frederick, Maryland 21. Signature of Fune 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA 7606 Old National Pike Boonsboro, MD Enter the disease, or complications that or heart failure. List only one cause on e hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock Interval Between Immediate Cause (Final Onset and Death Physician/ moni disease or condition resulting in death) **Medical** Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami transit and that initiated events resulting in death) Last Due to (or as a consequence of) burialattending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Day Pregnant at time of death 5 Other (specify) Month signed by the a d be detached f 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed' After this certificate 1 Yes 2 No Yes 2 N To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital No ဂ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident (Month, Day, Year) 5 Pending injury 1 Yes 2 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 032518 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Decedent's Name (First, Middle | Last) 2. Date of Death Physician/ December 26, 2011 4:26 PM Robert J. Reed Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Northampton Manor Nursing Home Frederick Frederick 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours Dec. 15, 1927 192-24-8114 **Director** 1 XM 2 □ F 84 Pennsylvania Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21704 United States 8033 Ball Road ural", or items 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces? 10 Black, White, etc. 1 Never Married 2 Married Yes, Give Completed by 2 No Maryland 21215-0036 Il Hygiene. 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 Divorced White 145-147 Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Retail Sales Salesperson marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Sarah E. Keil Myron W. Reed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health 8033 Ball Road, Frederick, Maryland 21704 Michael Reed / Son Baltimore, item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) December Smithsburg Crematory 28 2011 Smithsburg Maryland 21. Signature of Funeral Service L Keeney and Basford PA Funeral Home, 106 East Church Street, Frederick, MD 21701 MO1473 23a. P. 1. Enter the disea shock, or heart failure. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final Onset and Death Dements a-Ph_sician/ Severe disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner theit andor Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Due to (or consequence of) Examin Cause (Disease or injury that initiated events the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 No detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ be 60A 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has performed 1 Yes 2 No the Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Deat_ (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: ဂ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man or of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No s after death. Accident M Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 700 Montelaire HAQUE State JAN 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Funeral		5. Social Security Number 6. Sex	7. Age	e (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day	h v, Year)		Birthpla Co <i>untr</i> y	ce (State or F)	oreign
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Maryland 21215-0036	within 72 hours after death with the Maryland gene. ier than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates.		1	Yes 2 No	Specify:			Spe	cify:	whi	te	
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Σ.	and 2 s Health em 27		Michael Rhodes/son	<u> </u>			Fort Ave	enue,							
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Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee		Mt.	Zion	Cem. Name and Addre	es of Facilit	12/1		Swant				
Ba	permi Depar Impo any ir	75	21. Signature of Funeral Service Licensee	arther	TI.	P			Mar	kwood 1 r. WV 1		ıl Hoi	me,	Inc.	
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Bo	the at	ysic	1 Yes 2 No 9 Unknown	4 ☐ Pregnant a 9 ☐ Unknown	it time of a	leath 5 ∟	Other (specify)								
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Division of Vital Records,	Atter er dea ector by the	Certificate:	3 Suicide 6 Could not be		eet, factory, office	-	2	28f. Location (umber or	Rural I	Route Numbe	r,		
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	Hospi 4 hou Funer tely fil	Medical	29a. Certifier 1 Certifying Physic (Check 2 Medical Examine	er. On the hasis of e	examination	and/or invest	tigation in my opin	ion, death o	occurred at	the time, date a	and place, an	id due to ti	he cau	se(s) and mani	ner stated.
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	M	only one) 3 Certifying Nurse 29b. Signature and title of certifier	Practitioner: To the	e best of n	ny knowledge	, death occurred at 29c. Licens	the time, da	ate and plac	ce, and due to	the cause(s) a 29d. Date s	and manne	er as si	ated.	
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	,		30. Name and address of person who cor	mpleted cause of c	leath (Item	23a) (Type, F	Print) Am in	+ Bh	ANO	JARI					
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	Sta Registr	te ar	30. Name and address of person who con WMHS 12 5 0 0 31. Date filed (Month, Day, Year) JAN 0 4 2012	3. Registr	ar's Signat	lare ba	Kel								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Day SAID 2011 22 Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death **Examiner** 4c. County of Death MONTGOMERS OCKVILL 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 78-23-4858 Min. **Director** 1 🗆 M 2 💢 F 09 ALGERIA 28a-f show 10c. City, Town or Location Director must be notified MONTGOMER BETHESDA 1 Yes 2 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 4521 WEST 20814 ALGERIA "natural", or items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 🗙 No Specify. Completed 3 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) HOME MAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LGAH HADI 19a. Informant's Name/Relationship (Type, Print) DAUGH TER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RECHACHE ETERNITY RD GERMANTOWN MD 20874 20b. Place of Disposition (Name of cernetery, crematory or other place)

AFMARU 12 /23/11 FREDERICK 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ADEN MUSLIM FUNERAL ST. WOODBRIDGE VA-22/91 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death ute Physi∟ian Kinnes disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consumence of nding physician and use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

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1 Yes 2 No Hospital: Other: ည 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? 2 🗌 No 2 Accident
3 Suicide Investigation Director , 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined City or Town, State) within 24 hours

To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) DEBRAH MILLER GOOL MUNCASTER MILL RD. ROCKVILLE MD

Registrar

DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend#1 per PHY State of Marylan 1 = State 12/13/2011 AACO HEALITH DEPT. CMH Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Mafalca Katherine Stanzione 2. Date of Death 3. Time of Death Physician/ Mafalda Kathern Stanzione December 11, 2011 9:33 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 15105 Peartree Dr. Prince George's Bowie 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Min Hours Director 152-12-9961 1 🗆 M 2 🗶 F Apr. 13, 1924 New Jersey 87 or 28a-f show 10a. State 10b. County Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits Director MD Prince George's Bowie 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 15105 Peartree Dr. USA 20721 death v 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. þ 1 Never Married 2 Married ☐ Yes 2X No Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2X No Specify: If Yes, Give Completed 3 ☒ Widowed 4 ☐ Divorced Year or Dates White event, the Medical 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ Guistino Genovese Julia Tontini and 2 should the 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains Dan Carson / Son-in-law 15105 Peartree Dr., Bowie, MD 20721 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place N.J. Veterans Mem. 1 XBurial 2 Cremation 3 Removal from State 12/19/2011 4 ☐ Donation 5 ☐ Other (Specify) Arney Town, NJ Cemetery 21. Signature of Funeral Service Licensee Beall Funeral Home 22. Name and Address of Facility 6512 NW Crain Hwy., Bowie, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition men Medical resulting in death) Examiner eavs Sequentially list conditions Examine duly, leading to immediate cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Australity 1 Yes 2 No 3 Probably 4 Unknown Chronic obstructive Pileule. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 卢 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Mann - f Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 20905 12/12/ 2011 Many andree 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gerard Champaloux

Registrar

State

lane

Bowie

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Gallant

Fox

32. Registrar's Signature

14300

31. Date filed (Month, Day, Year)

OEC 1 2 2011

Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0scar Schuhart, Sr. .Iohn 2011 7:45 p December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's 5. Social Security Number 3602 Mary's Hospital Leonardtown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland 1 🗷 M 2 🗆 F Months Days Hours Min 09/04/1922 89 Director 218–14–4665 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director 1 Yes 2 No Maryland St. Mary's Chaptico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Funeral 23a 20621 USA 25043 Maddox Road items ; hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 2 Yes 2 No Black, White, etc. ō ģ 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give "natural", Specify: 3 Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Farmer Farming Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Edward Schuhart Nellie Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sl ment of Health a tant: If item 27 is Judith Richards/Daughter P.O. Box 624, Chaptico, MD 20621 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. cemetery, crematory or other place) 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Sacred Heart 12/22/2011 Bushwood, MD 4 ☐ Donation 5 ☐ Other (Specify) Sunatur of Funeral Service License Mattingley—Gardiner Funeral Home, P.A 41590 Fenwick St., Leonardtown, MD 20650 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiopulmonary Arrest disease or condition resulting in death) Medical Due to (or as a consequence of): . Examiner Myocardial Infarction Sequentially list conditions, Examine Tue to for as a consequence of: that the death certificate be executed use as the burial-transi Cause (Disease or iinjury and that initiated events Due to (or as a consequence of): resulting in death) Last physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) ed by the a detached f 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Chronic Renal Failure or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 X Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Dementia 24a. Was an autopsv 1 ☐ Yes 2 🛣 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 🎛 No director, Be 26. Place of Death (Check only one) မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 🔀 Natural injury To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) certifier 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D0072816 12/18/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10+ ene 25500 Point Lookout Rd., Leonardtown, MD 20650 Mohamed Mwinyimvua-Mohamed 31. Date filed (Month, Day, Year) State Registrar DEC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 21, 2011 5:58 p Margaret **Viola** Schuhart December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital Leonard town St. Mary's If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 03/26/1926 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 □ M 2 1 F Director 218-24-3128 Usual Residence of Decedent 85 Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 No Director Maryland St. Mary's Chaptico 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a and Injury or other traumatic event, the Medical Examiner must once. 25043 Maddox Road 20621 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 No Specify: 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fredrick E11a Harris Augusta Murphy Gwenette ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Richards/Daughter P.O. Box 624, Chaptico, Maryland 20621 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 12/22/2011 Sacred Heart Bushwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A. 21. Signature of Funeral Service Licens 41590 Fenwick St., Leonardtown, MD 20650 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ardide arrithma menutes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Napapia Sequentially list conditions, it as a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consuluence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☐ No 1 ☐ Yes 2√2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

P.O. Box 68760, Division of Vital Records, genunart,

certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burlal-trans

'natural', or items 23a or 28a-f show dical Examiner must be notified at

21215-0036

altimore, Maryland

spital or Attending Physician: Thours after death.
Ineral Director: After this certificatly filled in by the funeral director, pa Hospital

thin 24 hours a Medical

10 Rme State Registrar

မ Certification:

1 Yes 2 No

29a. Certifier

(Check only one)

27. Manner of Death 1 V Natural 5 Pending 2 Accident 3 ☐ Suicide

investigation 6 Could not be determined 4 Homicide

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28a. Date of Injury (Month, Day, Year)

Jaum Demalari

29c. License number 0>9821

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) December 21,2011

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CeonARDTOUR, MD

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

JAMES DAMALOUT 80 Box 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ $\overset{\text{Day}}{1}4$ Robert Sullivan Coyle December 04:45 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2021 Huntingfields Drive Calvert Huntingtown Social Security Number 8. Date of Birth (Month, Day, Year May 29, 1 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 579-26-8064 1 X M 2 🗆 F Washington, 84 **Director** May Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director Calvert 1 Yes 2 No Maryland Huntingtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2021 Huntingfields Drive 20639 12. Was Decedent Ever in U.S. Armed Forces?

1 ▼ Yes 2 □ No If Yes, Give 1, 1, 1, 1 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates. W.W. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ years Library of Congress Librarian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Catherine Coyle Daniel J. Sullivan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara M. Sullivan/ Wife 2021 Huntingfields Drive, Huntingtown, MD 20639 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 12/17/11 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signat of Funera 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ a METASTATIC UND FFERENTIATED CARCINOMA disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions Examine cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Pregnant at time of death Year 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 🖳 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 \square Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause death (Item 23a) (Type, Print) JOL FREDERICK no 31. Date filed (Mo State Registrar

DHMH 17 Flav 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Day 201°f 8:19 am 9 Fannie Mae Smith Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Worcester Hartley Hall Nursing Home Pocomoke 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** (Month, Day, Year) -15-1930 Min. Country) 1 □ M 2 🔽 F Director 219-60-1480 Usual Residence of Decedent 28a-f show 10d, Inside City Limits 10a, State 10b. County 10c. City, Town or Location notified at Director 1 Yes 2X No Pocomoke MD Worcester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō or other traumatic event, the Medical Examiner must be 23a Funeral 21851 105 Laurel Street items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 XNo 1 Never Married 2 Married ò by 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. SpecifBlack permit. Page 1 and 2 should be filed within 72 hours aff Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exa 3

Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 11 Homemaker <u>Housewife</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Isabelle Sample Roosevelt Finney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurel Street, Pocomoke, MD 21851 Glinda Smith/Daughter-r 105 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12-19-2011 Dover, DE Cremation, 22. Name and Address of Facility 17 W. Isabella St. Bennie Smith 21. Signature of Funeral Service Licenses Funeral Home Salisbury, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final oma Physician/ e disease or condition resulting in death) Medical Due to (or as a cons vence of) Examiner Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day 1 Yes 2 No been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an autopsy performed? Yes 2 No prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2.XNo ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Kcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c. License number 12-13-2012 0054422 ause of death (Item 23a) (Type, Print) 30. Name and address of person who com 165 4-Market 31. Date filed (Month egistrar's Signatur State

DHMH 17 Rev 7/2009

Registrar

11-09126 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene David Allan Seibold 2011 42532 1- For State Registrar Reg. No Physician/ 1. Decedent's Name (First, Middle Lest) 2. Date of Death Time of Death Month Day December 4, 2011 **Medical Examiner** 1138 hrs David Allen Seibold 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 127 I Georgia Avenue Ocean City Worcester 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days oreign Hours Director 053.24.1601 82 1 X M 03/14/1929 2 F Country) NY Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits is 23a or 28a-f show e notified at once. MD Worcester Ocean City 1 X Yes 2 No imore, MD 21215-0036

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygene.

part: If item 27 is marked other than "natural", or items 23s or 28s-f sho or other traunatic event, the Medical Examiner must be notified at once. rector 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 127 I Georgia Ave 21842 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Yes 2 No 4 Divorced If Yes, Give Year Army 3 Widowed 1 Yes 2 No specify: Specify: white ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Merchant Marines US Gov. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) George Seibold Helen Filip 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Beistein (niece) 6205 Thomas Dr. Springfield VA 22150 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State ltimore, Date 1 Burial 2 Cremation 3 Removal from State crematory or other place) 12-15-11 mportant: Nassau Knolls Port Washington NY Donation 5 Other Specify 22. Name and Address of Facility ${\rm The}$ 108 William St. Burbage Berlin, the disease, or complication s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval /Medical Between Onset and Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician and red for use as the burial - transit Physician/Medical AMENDED pt.II, per me, g925 3-14-12 sm UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery dent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Year 2 Day past 12 months? Pregnant at time of death 5 Other (Specify) isigned by the atterd be detached for u 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Diabetes Mellitus Completed ficate has been s , page 2 should b 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of After this certificate has performed? death? Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene 1 ✓ Yes 28a. Date of Injury (Month, Day, Yaa 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natural 5 Pending 1 Yes 2 No the 2 Accident Investigation completely filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be within 24 hours at determined Homicide 29a. Certiffer 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated **Wedical** 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

BA Ca+

Theodore M. King, Jr., MD. 31. Date filed (Month, Day, Year) State

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 32. Registrar's Signature

arks

OCME

December 5, 2011

O.C.M.E.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 8, 2011 4:40 A M Robert K. Snow Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's 17226 Mill Branch Place Bowie Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Hours Min **Director** 214-52-4539 1 **№** M 2 🗆 F 60 May 30, 1951 Washington, D.C. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2 No 28a-f MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö must be r Funeral 17226 Mill Branch Place 20716 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Examiner Armed Forces? Black, White, etc. ō þ 1 Never Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White "natural" 3 Widowed 4 Divorced Completed al Hygiene. I other than "natura vent, the Medical E 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) NBC/WRC Channel 4 College (1-4 or 5+) Elementary/Secondary (0-12) Electronics Engineer Washington, D.C. of Health and Mental Hygie if item 27 is marked other r other traumatic event, the Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) မ Anna Margaret Ward Robert Elwell Snow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17226 Mill Branch Place, Bowie, MD 20716 Marie E. Snow Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ō cemetery, crematory or othe Metro Crematory 1 Burial 2 Cremation 3 Removal from State crematory or other place. ± 5 Department of Important: If any injury or 12/9/2011 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Beall Funeral Home 22. Name and Address of Facility 6512 NW Crain Hwy., Bowie, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death ⊶Ph_si_ian Brain Tumor - Glioblastoma disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter chaenying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events -tran and Due to (or as a consequence of): resulting in death) Last -pnualattending physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Year be detached Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records. 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an page 2 s autopsy certificate Yes 2XXNo To the Hospital o Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 8c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work?
1 Yes 2 No within 24 hours after death.

To the Funeral Dilector Al Accident Investigation the 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

completely 104

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arun Bhandari, MD,

Bhow

129 Lubrano Dr., Ste. 201, Annapolis, MD

D66818

29c. License number

29d. Date signed (Month, Day, Year)

12/8/2011

State Registrar

only one) 29b. Signature and title of certifier

31. Date filed (Month, Day, Year) DEC 12 2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month /2 OUERNS NNI 01:20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Mandrin Chesapeake Hospice House Anne Arundel Harwood Social Security Number 7. Age (In yrs. last birthday)
40 yrs 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
July 14,1971 **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🟋F Months Days Hours Min. 153-55-5436 New Jersey **Director** July Usual Residence of Decedent ms 23a or 28a-f show must be notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Severna Park 1 Tes 2 X No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 709 Pin Oak Road 21146 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian traumatic event, the Medical Examiner Armed Forces Black, White, etc. þ 1 ☐ Yes 2 🔀 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Social Worker School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Terrana Jeanne Wilke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Richard Soverns / Husband 709 Pin Oak Road Severna Park, MD 21146 other 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any Injury or ot 20c. Location - City or Town, State December 13 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Baltimore, MD Metro Crematory, INC. 2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sors, 495 Ritchie Hwy, P.A. Severna Park Funeral Home Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart affure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physici. ECULCIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the burial-transit Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physiciar Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 as IF FEMALE asn 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Pregnant at time of death Other (specify) Month Day Year 4 ☐ Pregnant a 9 ☐ Unknown 2 No signed by the a d be detached f 1 ☐ Yes 2 L 9 ☐ Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? þ icate has been sig r, page 2 should b 1 ☐ Yes 2 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 2 🗌 No Yes 2 2 1 Yes funeral director, 25. Was case referred to medical Be HOS ILE 26. Place of Death (Check only one) Mandrin House 2 12 No Other: မှ 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending To the mospine. within 24 hours after death.

To the Funeral Director. Aft work' М 1 🗌 Yes 2 🗌 No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Date filed (Mon istrar's Signature State Registrar

arol D. Simmons	State of Maryland / Department of Health and Men							
	1- For State Certificate of Death		2011 4253					
Physician.	Registrar	Reg. 2. Date of Death	3. Time of Death					
ledical Examine		Month December 2	ay 2011 Year 0945 hrs					
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location	of Death	4c. County of Death					
	472 Rita Drive Odenton	To pay against	Anne Arundel					
Funeral Director	Months Days Hours	Min	MM/DD/YYYY) 9. Birthplace (State or Foreign					
5,100,01	216-50-9860 1 M 2 → 59 Yrs. World Says 10 M 2 → 10 M 2 → 10 M 2 M 2 M 3 M 3 M 3 M 3 M 3 M 3 M 3 M 3	9/3/19	Country) MD					
ku a	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits					
È.,	MD Anne Arundel Odenton		1 Yes 2xx No					
the Maryland a or 28a-f sho tified at once.	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Country?					
the N	472 Rita DR. 21113		USA					
r death with or items 23 const be no	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic On If Yes, specify Cuban, Mexican		14. Race - American Indian, Black, White, etc.					
r deat	1 Never Married 2 Married 1 Yes XX No							
ural",	3 Wildowed 4XX Divorced in res, Give rear 1 Yes 2XX No specify:		Specify: White Sb. Kind of Business/Industry					
2 hou "nat	Elementary/Secondary (0-12) College (1-4 or 5+)		b. Rind of Edsiriossimidastry					
5-0036 ed within 72 hour tygiene. other than "natu the Medical Exan	2 RN		Health Care					
15-0036 filed within 72 1 Hygiene. do ther tean ' t, the Medical	17. Father's Name (First, Middle, Last) 18.Mother	's Name (First, Middle, Maio	den Surname)					
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medical		rgaret Tucker						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Num Robert Simmons Son 1065 Overcrest Di		r, City or Town, State, Zip Code) .1e, MD 21032					
and 2 fealth trem 2	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,		Oc. Location - City or Town, State					
JOF ages 1 nt of F ether	1 Burial 2XX Cremation 3 Removal from State crematory or other place) Atlantic Crematory	12/28/2011	Glen Burnie, MD					
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite injury or other tr	4 Donation 5 Other Specify: 21. Signature of Funery Psycice Licensee 22. Name and Address of Facility	V						
De De M	12 Ridgely Ave.	Hardesty Fun Annapolis,	eral Home, P.A. MD 21401					
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as c failure. List only one cause on each line.							
/Medical Examiner	Immediate Cause (Final disease a Atherosclerotic Cardiovascular D	isease	Death					
,	or condition resulting in death) Due to (or as a consequence of):							
er er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):							
ted Insit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of):							
ansit Ex.	events resulting in death) Last Due to (or as a consequence of): d.							
executed ian and ial - transit	☐ AMENDED 23a, 27, per me 29289272 1722 TRT	sm						
box 68760, the death certificate be the death certificate be by the attending physiciched for use as the buriched for use as the burilend for	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery					
OX 687 sath certiful attending for use as t	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic	pregnancy	Month Day Year					
Box the death of the attented for us	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa	art I. 23e. Did tobac	cco use contribute to the cause of death?					
s, P.(ires that signed the deta	Chronic alcoholism	1 Yes 2	2 No 3 Probably 4 ✓ Unknown					
ords w requires should should		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of					
Records, The law require: Ifficate has been significate .		performe 1 Y Yes 2						
of Vital Records ig Physician: The law requirant the trib certificate has been neral director, page 2 should it. To Be Complete	25. Was case referred to medical examiner?							
Physic rathis rad dire	1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA		sidence 6 Other: Scene					
n o o o o o o o o o o o o o o o o o o o	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work		injury occurred					
Division Island or Attendin rs after death. al Director: A led in by the fu	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory office building, et		et and Number or Rural Route Number, City					
Division or spital or Attending hours after death. In meral Director: Aft filled in by the fune Certification:	Suicide 6 Could not be determined (Specify)	or Town, State						
	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death-occurred at the time, date and plate (Check only)	ace, and due to the cause(s)	and manner as stated.					
To the Hospi within 24 hou To the Runel completely fi	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death oc	curred at the time, date and	place, and due to the cause(s)					
43F3								
0,	Carol Hallan wed for TYK O.C.M.E.		ecember 24, 2011					
8	30. Name and address of person who completed cause of death (Item 23a) Theodore M. King it. MD. Assistant Medical Evaminer, 200 W. Raltimore Ste	act Raltimore MD 2	1222					
Ctat	Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Str. 31. Date filed (Month Dev.) 2011 32. Registrar's Signature	eel, Dailinoie, MD 2	1223					
State Registra	St. Date filed (MONTHE 176 2011 Server S. Dark)							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2011 7:58a December Anthony Leo Schleicher Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Frederick Monrovia 3359 Kemptown Church Road 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday, **Funeral** Hours Director 214-60-3673 1 X M 2 | F 59 Feb. 28, 1952 Massachusetts Usual Residence of Deced th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County Director 1 Yes 2 X No Frederick Monrovia Maryland 10f. Zip Code 10a. Citizen of What Country? 10e. Street and Number Funeral United States 21770 3359 Kemptown Church Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) High School English Teacher 5+ Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Ann Ward William Earl Schleicher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print, Department of Health ar Important: If item 27 is any injury or other trauonce. 3359 Kemptown Church Road, Monrovia, Maryland 21770 Anne D. Schleicher/ Wife Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Stauffer Crematory Inc. 12/14/2011 Frederick, Maryland. 4 Donation 5 Other (Specify) 21. Signatur of ral Service Wence 22. Name and Address of Facility
Stauffer Funeral Homes P. A.
1621 Opossumtown Pike, Frederick, Maryland 21702 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lir sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition Physician. Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of, and the burial-trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IE EEMALE Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months? Month Year Pregnant at time of death 1 Yes 2 No 9 Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 26. Place of Death (Check only one) director, Be 25. Was case referred to medical Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 2 No 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred Certificate: 5 Pending Accident Investigation of Funeral Director: # 6 Could not be 28f. Location (Street and Number or Rural Route Number, Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2, To the F complet only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3 2011

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Diane Ruckert CNP 516 Trail Avenue, Frederick, Maryland 21702

31. Date filed (Month, Day, Year)

egistrar's Signature . Larke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ Ellen May Shaffer Decembe Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** harle Medical Plato La Conter 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Year 1927 Funeral 1 □ M 2 F Nov. 23 Min. 214-26-4827 Virginia 84 Yrs Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State death with the Maryland Director 1 Yes 2 X No Maryland Charles LaPlata 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A 6376 Nelson Road 20646 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. by 1 Never Married 2 Married 72 hours after 1 ☐ Yes 2 🔀 No Specify: Specify: White If Yes, Give Completed 3

Widowed 4 □ Divorced Year or Dates. 16b. Kind of Business Industry 16a. Decedent's Usual Occupation Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic event, the M Elementary/Seconday (0-12) 12 College (1-4 or 5+) Personal Training Specialist U.S. Government Be 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) ည Mary Ellen James Chester B. Mills 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6055 Champmans Landing Rd., Indian Head, Md. 20640 Sue A. Wheeler Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Dec . 19 pate 2011 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 Cremation 3 Removal from State Waldorf, Maryland Trinity Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Williams Funeral Home, P.A. Signature of Funeral Sen M00668 4270 Hawthorne Rd., Indian Head, Md. ease, or complications that caused the durth. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the shock, or head lure. List only one cause on each line Onset and Death Immediate Cause (Final Pnysician/ disease or condition) Medical resulting in death) Due to (or as a consequence of): **Examiner** (NOT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events coulting in death) Last Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed page 2 should be detached for use as the burial-transit attending physician and Due to (or as a consequence of): resulting in death) Last Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) Pregnant at time of death 9 Unknown signed by Part II. Other significan conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 1 Yes 2 No certificate Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes Inpatient 2 ER/Outpatient 3 DOA Certificate: To 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 28c. Injury at work?
1 Yes 2 No iniury 5 Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar's Signatur State Registrar

844860W

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 12-Physician/ Calvert Smith 16-11 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George Southern Maryland Clinton If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 11-28-1925 Days Country 216-22-2739 1X M 2 F 86 **Director** Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location Director Yes 2 No Upper Marlboro Maryland Prince George 10g. Citizen of What Country? 10e, Street and Numbe by Funeral USA 20773 13507 Old Marlboro Pike Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married ☐X/es 2 ☐ No Yes, Give 1951 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Black 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) PNC Bank Courier 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Baden Gertrude Smith, Sr William 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20773 19a. Informant's Name/Relationship (Type, Print) 13507 Old Marlboro Pike, Upper Marlboro MD Delores Smith/ Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Cheltenham MD 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cem. 12-22-11 21. Signature /f uneral Service Licensee 22. Name and Address of Facility MD 20608 Adams Funeral Home PA, Aquasco 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Chronic LymphocyVic Physician/ disease or condition resulting in death) Medical Due to (or as a co-sequence of) **Examiner** LevKemic plic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Syndrome AVH To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury inding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical evilleval Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death the s 9 Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? obstructul Du (momary 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available 24a. Was an adenoma prior to completion of cause of death? Hypertension performed 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 횬 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: within 24 hours after death.

To the Funeral Director: After completely filled in by the funer 1 Natural work? injury 5 Pending Accident 2 🗌 No Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29h. Signature and title of centi-2042049

00-5

State Registrar 31. Date filed (Month)

MD.

32 Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

xpper Manlbovo. MD

20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND 4A-4C, 25, PER M.E. G929 //16/12 TRT State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ 9:55 AM SEYMOUR 201 LARENCE Medical 4c. County of DeathANNE ARUNDEI 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner INFIRMARY INTIMAR Jess Jessup CorrectioNA Institute If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthda) Funeral -1950 Washington D.C (Month, Day, Year) Hours Min. **Director** 579-68-3431 Usual Residence of Decedent 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County death with the Maryland Director 1 ☐ Yes 2 🎗 No Jessup Maryland Ann Arundel 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 20794 Jessup Correctional Institute Rd. Funeral U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11, Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give 1 Never Married 2 Married þ 3altimore, Maryland 21215-0036 Specify: White 1 Tyes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates the Medical 16b. Kind of Business Industry 16a Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Auto Parts Co. Auto Mechanic 8 permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lida Marie BenDino-Meontante Clarence S. Seymour, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20616 3043 Warehouse Landing Rd., Bryans Road, Md. Son Charles Seymour 20b. Place of Disposition (Name of cemetery, crematory or other place) Dec. 12, Date 2011 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Trinity Memorial Gardens Waldorf, MAryland 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility}
Williams Funeral Home, P.A.

4270 HAwthorne Rd., Indian Head, Md. 21. Signature of Funeral Service Light M00668 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Stage IV Non small cell LUNG Immediate Cause Metastatic Cancer €nysician/ Month disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying CERTIFICATION APPRISED TO THE DICAL EXAMINER Due to (or as a consequence of): Examine Cause (Disease or iinjury that initiated events resulting in death) Last and -tran Due to (or as a consequence of) burial physician s the burial Physician/Medical certificate be Records, P.O. Box 68760 as attending 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Day in the past 12 months?
1 ☐ Yes 2 ☐ No for Pregnant at time of death signed by the at d be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ FAILU Re 1 Yes 2 No 3 Probably 4 Unknown RENAL Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an topeNIA autopsy performed? Yes 2 No has death? 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 St Other (Specify) PRISON 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ 28a. Date of injury (Month, Day, Year) 28c, Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State) Medical Example 2 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 9 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number D0052560 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jess JRI AyAlew Melaku 31. Date filed (Month, Day, Year) State 1 4 2011 Registrar

Box 68760

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Hilda Smith December 27 Mae 2011 5:30 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Golden Living Center - Frederick Frederick Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 218-38-0910 91 **Director** 1 M 2 X F Yrs February 17, 1920 Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1 🗌 Yes 2 🙀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5672 Crabapple Drive United States of America 21703 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. þ 1 Never Married 2 Married ☐ Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: "natural", Completed 3 X Widowed 4 Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 10 Seamstress Textile Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William David Ferrell Lettie Olivia Gross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Bernard Smith, Jr. / Son 47 Edgewater Drive, Heathsville, Virginia 22473 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State December 31. 1 K Burial 2 Cremation 3 Removal from State Resthaven Memorial Gardens Frederick, Maryland 4 Donation 5 Other (Specify) 2011 22. Name and Address of Facility **Keeney and Basford P.A. Funeral Home**106 Fast Church Street, Frederick, Maryland 21701 Signature of Funeral Service Licenses M01433 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. erval Between Immediate Cause (Final disease or condition Onset and Death ERINE Physician Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence on that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical phys the t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown 9 Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Tunknown Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy 1 Yes 2 No Yes To the Hospital or Attending Physician: "
within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, to 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work?
1 Yes 2 No Investigation 2 Accident

Box 68760 P.O. Division of Vital Records,

Medical

State Registrar

29b. Signature and title of ce

Suicide

4 Homicide

29a. Certifier

(Check

6 Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

28f. Location (Street and Number or Rural Route Number.

TOLL HOUSE FREDERICK, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Genevieve Sheridan I8, December 2011 2:10 A MMedical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death National Lutheran Home Rockville Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth (Month, Day, 1 - M 2 X F Months Days Hours New York Director 066-14-9274 99 June . 191 Usual Residence of Decedent 28a-f show 10b. County 10c. City. Town or Location with the Maryland 10d. Inside City Limits Director notified 1 X Yes 2 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code ō 10g, Citizen of What Country? pe r items 23a o Funeral 9701 Viers Drive 20850 IISA . Page 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hygiene. tant. If item 27 is marked other than "natural", or items lury or other traumatic event, the Medical Examiner mu 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Factory Worker Ball Bearing Plant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Michael Sheridan Mary Flynn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynn O'Leary/Niece permit. Page 1 and 2. Department of Health Important: If item 27 any injury or other tr 4013 63rd Street Bethesda, MD 20816 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dec.Date 20, 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State cemetery, crematory or other place) Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2011 Alexandria, Virginia 21. Signature of Funeral ervice Licensee 22. Name and Address of Facility DeVol Funeral Home M01315 2222 Wisconsin Ave., NW Washington, DC 20007 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ emorrh GAST ROINTESTINA disease or condition 4 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events sician and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 2 Li Feta 3... 4 Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) ____ ned by the atter detached for u in the past 12 months? Day 9 Unknown 9 Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown End Stage Dementic 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 ☐ Yes 2 ₺No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 8 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at work?

1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) D0050612 M

State Registrar 70/ Veirs Drive Rockuille

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mallon

MD

32. Registrar's Signature

11-09	746		
Greg	Todd	Smith	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		C	ertificate	e of	Death					Reg. No.			
Physicia	an/	1. Decedent's Name (First, Mid-									Date of De Month		Year	,	3. Time of Death
ledical Exami	ner	Gregory	Todo		Smi		0: -				Month Decembe				1958 hrs
محلو		4a. Facility Name (if not institut 220 Somerville Aven		mber)		40	b. City, Tov Cumbe		ocation of	Death			: County or Allegany	f Death	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	s. last birthda	ay)	If Under Months	1 Year Days	If Under Hours	24Hrs. Min.	8. Date of B	irth(MM	(DD/YYYY)	9. Birti Foreign	hplace (State or Maryland
Director		266-67-1866	1 X M 2 F	48		Yrs.	MONTHS	Days	nours	Willi.	05/05	/19	63	Cou	intry)
<u> </u>		Usual Residence of Decedent 10a. State 10b. County	,	Inc. Ci	ity, Town or I	ocatio	nn .								10d. Inside City Limits
OW ROY		MD 100. Coding	Allegany	100. 0	•		"' berla	nd							1 X Yes 2 No
yland r-f sh	ţ	10e. Street and Number	Allegally				10f. Zip C				ı	10a Citi	izen of Wha	at Courn	
death with the Maryland or items 23a or 28a-f show must be notified at occe.	Director	220 Somervi	lle Avenue	, Apt	711		101. Zip 0		502			-	USA	at 00011	u y r
th with	Funeral	11. Marital Status 1 X Never Married 2	12. Was Dec	edent Ever in orces?	U.S. 13	3. Was	Decedent s, specify (of Hispa	anic Origii Mexican, I	n? (Spec Puerto Ri	cify Yes or Nican, etc.)	0-	14. Race - White		can Indian, Black,
er dea		3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify:									White				
urs afi tural'	d b	15. Decedent's Education (Sp	or Dates:		16a. Dec	cedent's	s Usual Od	cupatio	n (Give ki			16b.	Kind of Bus		
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. fant: If item 27 is marked other than "oatural", or item or other traumatic evect, the Medical Examioer must in	Completed	Elementary/Secondary (0-12			dur	-	st of workir orer	ng life. D	OO NOT u	ise retired	d)	Co	nstru	ıcti	on
d withingsene	E	17. Father's Name (First, Middle	e. Last)					118	3. Mother's	Name (F	First, Middle Je	Maiden	Surname)		
21215-0036 Juld be filed within 7 Mental Hygiene. marked other thao	å	Robert	Alvin		Smi										
D 2.	٩	19a. Informant's Name/Relation									ral Route Nu		-		
, MD and 2 sho eafth and em 27 is		Robert A. Sm	ith / fath		b. Place of D						Apt				and, MD21502 Town, State
Baltimore, permit. Pages 1 ar Department of Her important: If ite		1 Burial 2 X Crematic		om State	crematory umber	or other	erplace) d Cre	mato	ory		29/201				id, MD
Baltimo permit. Page Department o Important: injury or otl		4 Donation 5 Other 5	Specify: e-ticensee	/						Adam	ns Fam	ilv	Funer	ral	Home, P.A.
Balti permit. Departm Imports		Monor of	(2000xxx		ļ						Cum	-			21502
Physician		23a. Part I. Enter the disease, of failure. List only one caus		aused the dea	ath. Do not e						-				Approximate Interval Between Onset end
Medical		Immediate Cause (Final diseas		cation	s of d	liab	etes	mel	litu	s					Death
		or condition resulting in death)	Due to (or es a	consequence	e of):										
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		consequence	e of):										
ecuted and - transit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):													
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760, ficate be exe g physician at the burial -	Me	IF FEMALE:	23c. If yes, o	s note: outcome of pr	egnancy							23	TRT d. Date of o	delivery	
Sox 687 death certifi e attending for use as t	jan	23b. Was decedent pregnant in past 12 months?	I . L Live D	irth ant at time of	111	=	al death		Ectopic	pregnanc	У		Month	D	ay Year
Box 68 e death certif the attending ed for use as	Physician	1 Yes 2 No 9 U			death 5	_ Oth	er (Specif)	" _							
F, P.O. Be ires that the de- signed by the a be detached fi		Part II. Other significant cond	Itions contributing to	death but no	t resulting in	the un	nderlying ca	ause giv	en in Par	t I.	23e. Did	tobacco	use contrib	oute to t	he cause of death?
S, P	d be	Chronic alc	<u>ohol abuse</u>	: Нуре	rtensi	ve	ather	rosc	lero	<u>ti</u> c	1Y	es 2	No 3	Proba	abiy 4 🗹 Unknown
of Vital Records, P.O. Box 68760, og Physiciae: The law requires that the death certificate be ther this certificate has been signed by the attending physici meral director, page 2 should be detached for use as the burineral director, page 2 should be detached for use as the burineral	Completed	_ cardiovasc	ular disea	se							24a. Was	psy	pı	rior to co	opsy findings available ompletion of cause of
Rec The la cate h	E										1 ✓ Yes	ormed?		eath? ✔ Ye:	s 2 No
	Be	25. Was case referred to medic examiner?					26		f Death (0				_		
hysic this aldire	P	1 ✓ Yes 2 No		npatient 2	ER/Outpa	_		1000			Home 5				Scene
Division of Vital Hospital or Attending Physiciae: 24 hours after death. Fooeral Director: After this certificity filled in by the funeral director,	Certification:		28a. Date (Month)	of Injury , Day,Year)	28b. Tim	e of Inj			at Work?		8d. Describe	how inj	ury occurre	ed	
Division tal or Attendius after death. To Director: A led in by the fi	fical		estigation 28e. Place	e of Injury - Al	t home, farm	street	, factory, o	ffice bui	iding, etc.	. 21			and Numbe	r or Rur	al Route Number, City
Divinital o	4 Homicide determined (Specify)														
pe the the	Medical (Physician: To the best aminer:On the basis of	of examination											
wit vit	Me	29b. Signature and title of certif	and manner s	tated.	-		29c. l	icense	number			29d.	Date signe	d (Mon	th, Day, Year)
Y		When	Breall. Mi	D				D.C.M	.E.			Dec	ember 2	28, 20	11
4		30. Name end address of person				0.10	D.10			le:					
		Melissa Brassell, MD					Baltimo	re Str	eet, Ba	itimore	, MD 212	23			
Si Regis	ate trar	31. Date filed (Month, Day Year JAN 0 5 2012	Benera	gistrar's Sign	acke	1									

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42544 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DEC 2011 11:12 a M MARTHA TOBIN Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington Adventist Hospital Montgomery Takoma Park Birthplace (State or Foreign Country)
 DC Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Year 1945 Days July 14 1 M 2 X Hours Director 66 DC 578-60-8928 Usual Residence of Decedent show 10a. State 10b County 10c. City, Town or Location with the Maryland must be notified at 10d. Inside City Limits Director 28a-f 1 Yes 2X No MD Prince Georges Lanham 10e. Street and Number 10f. Zip Code þ 10g. Citizen of What Country? Funeral items 23a 20706 10104 Ellard Dr. USA 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc. 1 X Never Married 2 Married "natural", or ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Completed Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than within 7 College (1-4 or 5+) Elementary/Seconday (0-12) and Mental Hygiene. Executive Administrator DC Public Library 2yrs traumatic event, Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Odom Tobin Martha Ferguson Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health a item 27 i Lanham, MD 20706 10104 Ellard Dr. Dorothy Gray - Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit, Page 1 Department of I Important: If it ō cemetery, crematory or other place) injury or 1 X Burial 2 Cremation 3 Removal from State Landover, MD 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park 12-22-2011 Signature of Ineral Service License 22. Name and Address of Facility Marshall-March Funeral Home of Maryland ectorin Suitland Rd. Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician, disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran and that initiated events resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant Date of delivery Ectopic pregnancy 3 🗌 in the past 12 months?
1 Yes 2 No Pregnant 5 Other (specify) Pregnant at time of death Month Day Year detached the 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has performe 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 No Other: ပ္ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funeral Director: completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 🚨 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signatur 29c. License numbe 29d. Date signed, (Month, Day, Year) the and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar han

31. Date filed (Month, Day, Year)
DEC 2 3 2011

0

32. Registrar's Signal

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month / 2 4ROL EIBER 320 M 2011 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel 21 Treiber Lane Harwood Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Massachusetts 7. Age (In vrs. last birthday, 8. Date of Birth **Funeral** 1 🗆 M 2 🔏 F Months Days Hours Min **Director** 025-26-2706 78 Usual Residence of Decedent 28a-f show 10a. State 10b. County at 10c. City. Town or Location 10d. Inside City Limits Director notified Maryland 1 Tes 2 No Anne Arundel Harwood 10e. Street and Number rms 23a or 5 10f. Zip Code 10g. Citizen of What Country? Funeral 20776 USA 21 Treiber Lane items (Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married ò ģ 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates "natural", Specify. 3 Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Cultural Arts Elementary/Seconday (0-12) College (1-4 or 5+) Foundation Executive Director years of Health and Mental Hygie f item 27 is marked other r other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edwin Flynn Kathryn Condon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a Wallace Treiber/ Husband 21 Treiber Lane, Harwood, Maryland 20776 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of Important: If i any injury or conce. 1 🛣 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 12/20/2011 Davidsonville, MD Lakemont Cemetery 22. Name and Address of Facility George P. Kalas Funeral Home e Licensee 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Inset and Death Physician/ c/10~ disease or condition resulting in death) Medical Due to (or as consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): signed by the attending physician and de detached for use as the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has incompleted filled in by the funeral director, page 2: autopsy performed? 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2X No မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marian A. Parrott, M.D. 31. Date filed (Month, Day, Year) State **DEC 15 2011**

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 201 Medical acility Name (if not institution, give street 4b. City, Town, or Location of Death 4c. County of Death Examiner Arundel Arundel Medical Annapolis Anne Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthday) **Funeral** Hours Min. (Month, Day, 215-30-3423 **Director** 1 M 2 W Maryland Usual Residence of Decede 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland notified at Director 1 Yes 2 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a once. Funeral 303 Farragut Road 21401 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Caroline Rethschulte 2 Theodore Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula T. Sanner / Daughter 295 Riverside Drive, Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Kalas Crematory 1 Burial 2 X Cremation 3 Removal from State 12-13-2011 Edgewater, Maryland 4 Donation 5 Other (Specify) 21. Signature Funeral $^{22.\,\text{Name}}$ and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Ph_sician/ Medical Due to (or as a consequen of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury for use as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 ponths?
1 Yes 2 No Day Month Year 4 Pregnant at time of death 9 Unknown 5 Other (specify) is certificate has been signed by the a director, page 2 should be detached 9 Unknov Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Ninknown our bosis 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Yes 2/X No After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Hapatient 2 ER/Outpatient 3 DOA ၉ 1 Yes 2 No filled in by the funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Medical Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural injury 5 Pending death. Accident Investigation 24 hours after deatl Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) the 29b. Signature 29c. License number 29d. Date signed (Month. Dav. Year) 43371

State Registrar Judy H.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Herbert, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 42547 State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 12/13/2011 Physician/ 0200 Rose Marie Trent Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner AAMC Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. 5. Social Security Numbe 233-44-2526 8. Date of Birth g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 7/30/1930 Hours Min. WVA **Director** 1 ☐ M 2XXF 81 Usual Residence of Decedent or 28a-f show notified at 10d Inside City Limits 10c. City, Town or Location 10a. State Director 1 Yes 2XXNo Stevensville MD Queen Anne 10g. Citizen of What Country? 10e. Street and Number Examiner must be USA Funeral items 23a 21666 103 Little Neck Rd. death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Force Black White etc. ō 1 Never Married 2 Married þ Yes 2x X No 3altimore, Maryland 21215-0036 White 1 Yes XX No Specify "natural", Specify If Yes, Give 3 ₩Widowed 4 □ Divorced Completed Year or Dates. the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be filed and Mental H permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or one မ Freida Mae Garnetski Frank Puntigan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 103 Little Neck Rd. Stevensville, MD 21666 Georgiana Maszczenski daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 Burial 2 XXremation 3 Removal from State Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 12/15/2011 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Fhysician/ ongestive disease or condition Medical resulting in death) Due to (as a consequence of): **Examiner** Dequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami Hypertension
Due to (or as a consequence of): attending physician and for use as the burial-tran Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 month Day Month been signed by the a should be detached f 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown obstructive Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has performed death? this certificate h 1 Yes 2 No Yes 2 No the Hospital or Attending Physician: Thin 24 hours after death.

the Funeral Director: After this certifical myletely filled in by the funeral director, the funeral director is the funeral director. 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner?
1 Yes 2 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) **To** Hospital 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Mann of Death 28b. Time of 28d. Describe how injury occurred Certificate: iniury 1 Natural 5 Pending Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide determined City or Town, State) within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier The standard of the standard o (Check 29c. License number 29d. Date signed (Month, Day, Year) and title of certifie 3 12 2011 060390 Medical Hospitalist dress of person who completed cause of death (Item 23a) (Type, Print) MEDICAL CENTER ANNAPOLIS ADEEB ABER ANNE ARUNDEL 32. Pegistrar's Signature OEC 1 4 2011 State Registrar

Pleasa Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month DECEMBER Physician/ 2011 MADELINE TOTH 3:44 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 523 Gateway Drive, Frederick Thurmont 5. Social Security Number 579-24-9561 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Year 925 Hours New York 1 ☐ M 2X F 86 June 19 **Director** June Usual Residence of Decedent 10c. City, Town or Location
Thurmont 10b. County 10d. Inside City Limits with the Maryland 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director Frederick Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21788 523 Gateway Drive, West permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. Ş 1 Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white If Yes, Give Specify: 3 Widowed 4 ☐ Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Pearl F. Przygoda William J. Nowak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 21771 3014 Flag Marsh Road, Mt. Airy, Maryland Pam Davis - Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State of Heaven Cemetery 12-15-2011 Silver Spring, Maryland 4 Donation 5 Other (Specify) Gate 22. Name and Address of Facility Stauffer Funeral Home 21. Signarure of Funeral Service Liosusee Opossumtown Pike, Frederick, Maryland 21702 1621 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset shock, or heart failure. List only one cause on each line Immediate Cause (Final Privaterani disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 5 Other (specify) signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed Yes 2 1 Yes 2 No Yes 2 25. Was case referred to medical examiner? filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural After 5 Pending 1 Yes 2 🗌 No Investigation Accident 24 hours after deatl 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year)

State Registrar Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CKEL

31. Date filed (Month, Day, Year)

21702

180 Thomas Johnson Drive, Frederick, Maryland

To the Hospita within 24 hours To the Funeral completely fille	Medical
Stat Registra	
DHMH 17 Rev 06-2	2011

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		For State Registrar	State of M	/laryland		artment of tificate of		and N	В	teg. No. 2 U	Personnel	42549		
Physicia Medic	al	1. Decedent's Name (First, Middle CLARA ELIZABETI	H MUSE TEMPL						2. Date of Deat	BER 13, 2011 6:47 P				
Examin	er	4a. Facility Name (if not institution BRADFORD OAKS I	- ,			4b. City, Town,		of Death		PRINC		ORGES		
Funeral Director		5. Social Security Number 216-30-4151	6. Sex 7. A	ige (In yrs. Ia:		If Under 1 Yea Months Days		9. Birthpl Countr	lace (State or Foreign ry)					
M.		Usual Residence of Decedent			Yrs.				FEBRUARY	21,1937 V		INGTON, DC		
laryland 3a-f sh ified at	Director	10a. State 10b. County MARYLAND PRING	CE GEORGES		, Town or Loc OKEEK	eation					10	0d. Inside City Limits 1 Yes 2 □ No		
ith with the Maryland ms 23a or 28a-f show must be notified at	al Dir	10e. Street and Number		1100	OKEDEK_	10f. Zip Code			1	10g. Citizen of What Country?				
should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho 'aumatic event, the Medical Examiner must be notified at	Funeral	18605 DYSON LAN	12. Was Decedent	t Ever in U.S.	. 13. V	2060 Vas Decedent of	Hispanic Or	igin? (Spe	ecify Yes or No-	UNITED STATES 14. Race - American Indian,				
after de l", or it camine	by	1 Never Married 2 Mai	rried Armed Forces	2 D No	If	Yes, specify Cu	ban, Mexica	n, Puerto	Rican, etc.)	Black	, White, et	tc.		
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filed wi al Hygie I other vent, tl	Be	12TH GRADE 17. Father's Name (First, Middle,	Last)		PIENTA	L NEALI	18. Moth	ner's Nam	e (First, Middle, N	/laiden Surname)				
uld be il Menta narkec natic e	2	HARRY GROSE			1					YSON BR				
ge 1 and 2 should be filed within 72 hours after dea nt of Health and Mental Hygiene. : If item 27 is marked other than "natural", or iten or other traumatic event, the Medical Examiner.		19a. Informant's Name/Relations CEDALE P. TEMPI		HTER						City or Town, Sta (ARYLAND				
pe 1 and 2 s t of Health If item 27 i or other tra		20a. Method of Disposition 1 ▼ Burial 2 □ Cremation		20b. Pl	ace of Dispos	sition (Name of natory or other pi	ace)	1	Date	20c. Location - 0	City or Tov	wn, State		
Pa In India		4 ☐ Donation 5 ☐ Other ((Specify)	MARY						CHELTEN				
permit. Departr Importa any injt			N JOHNSON MOO	583	TH 34	ORNTON 39 LIVI	FUNERA NGSTON	L HO	ME, P.A.	N HEAD.	MARY	YLAND 20640		
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Medical Examiner		resulting in death)	Due to (or as	s a conseque										
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executed an and rial-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	s a conseque	ence of:	utia			+					
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ertificat ding ph	/Mec	IF FEMALE:	23c. If yes, outcome	e of pregnan	ncv					001.0				
requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 X No 9 Unknown		n 2 ☐ Fetal at time of de	Ideath 3 🗌	Ectopic pregna Other (spec <i>ify)</i>	ncy			23d. Date Mont		ry Day Year		
uires that t in signed b uld be deta	Completed by P	Part II. Other significant condition Chrome Kidne		but not resu	alting in the u	nderlying cause	given in Part	1.	23e. Did tob			e cause of death? ably 4 🗆 Unknown		
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hysicia nis cert I direct	To Be	examiner? 1 ☐ Yes 2 X No	Hospital:	atient 2 🗆 E	ER/Outpatien					ence 6 🗆 Other	(Specify)			
ding Pi h. After tl funera	cate:	27. Manner of Death 1 X Natural 5 Pendi		ijury Da <i>y</i> , Yea <i>r</i>)	28b. Time of injury					w injury occurred				
al or Atten s after deal I Director: ed in by the	Certificate:	2 Accident Investi 3 Suicide 6 Could 4 Homicide determ	mined 28e. Place of In	njury - At horetc. (Specify)		eet, factory, office		3110	28f. Location (St. City or Town	reet and Number n, State)	or Rural F	Route Number,		
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the b.	Medical	(Check 2 Medical I	g Physician: To the best of Examiner: On the basis of g Nurse Practitioner: To t	examination	and/or investi	igation, in my opi	nion, death c	ccurred at	the time, date an	d place, and due t	to the caus	se(s) and manner stated.		
Voir Con		29b. Signature and title of certifie					3351	2		9d. Date signed (
an A		30. Name and address of person				rint)								
Stat	0	DEIDRA VARNER, 31. Date filed (Month, Day, Year)	M.D. 11701	LIVII trar's Signatu		ROAD, S	SUITE	203,	FORT WA	SHINGTO	N. MI	20744		
Registra	ar	31. Date filed (Month, Day, Year)	1011 Senta	1.	par	W.								
MH 17 Rev 06-2	2011													

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 42550 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 12 Diana M. Williams 16 2011 14:01 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4h. City Town or Location of Death 4c. County of Death Southern Maryland Hospital Prince Georges Clinton Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min **Director** 212-88-6378 1 🗆 M 2 🕱 F Yrs. Usual Residence of Decedent 06/14/1950 Washington, DC 'natural", or items 23a or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10c. City, Town or Location is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits 1X Yes 2 No Prince Georges Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4701 Mimsey Road USA 12 Was Decedent Ever in LLS Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ <u>John Henry Williams, Sr</u> Nannie Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. <u> Margie J. Byrd - Sister</u> 4701 Mimsey Road Upper Marlboro, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 12/28/2011 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. Worn Montgomen 3401 Bladensburg Road Brentwood, MD 20722 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACCIDENT Physician/ CEREBROVASCULAR disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 DIABETES MELLITUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed DISEASE HUNTINGTON 1 Yes 21 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 \(\sum \) Yes 2 \(\sum \) No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify, မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Matural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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17/2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 21. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month ам 12 Carolyn Williams 2011 Medical 16 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Montgomery Takoma Park 9. Birthplace (State or Foreign Country) Washington, DC 8. Date of Birth (Month, Day, Year) 01/18/1951 If Under 1 Year If Under 24 Hrs. **Funeral** Age (In vrs. last birthday) 1 🗆 M 2 🕱 F Min. Director 577-70-2725 60 Usual Residence of Decedent or 28a-f show 10a. State 10b, County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No MD Prince Georges Rainier 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20712 USA 2901 Allison Street items ? 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after bepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic awant the Marier of Completed by 1 Never Married 2 X Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced Year or Dates Black 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Food Service Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ <u>Floyd A. Bates</u> Agnes Mims 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Agnes Mims - Mother</u> 4101 21st Street, NE Washington, DC 20018 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place. 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 12/27/2011 Brentwood, MD 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. Signature of Funeral Service Licensee 3401 Bladensburg Road Brentwood, MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed -tran and Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s 1 Tes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 ₺ No Hospita Other: 1 Tyes ၉ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛚 Natural 5 Pending injury work? 2 Accident
3 Suicide
4 Homicide 2 No Investigation M 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie

State Registrar

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31. Date filed (Month, Day,

<u>Nasreen Kango, MD</u>

7600 Carroll Avenue

Takoma Park, MD

20912

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 24, 2011 5:28 P M Francis Greenwell Wood, Sr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 23644 Bayside Road St. Mary's Clements 5. Social Security Number . Age (In yrs, last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Days Hours Min. 1172271939 217-36-9003 Maryland Director 72 Usual Residence of Decedent 28a-f shov 10a. State 10b. County be notified at 10c. City, Town or Location 10d, Inside City Limits Direct Maryland St. Mary's **Clements** 1 Yes 2 X No 10 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 23a must ! 23644 Bayside Road 20624 USA items death v 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 9 þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: 3 X Widowed 4 Divorced Completed White Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) e should be filed within 72 h h and Mental Hygiene. 7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) event, the Farmer Agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ **Bartholomew** Catherine Migonette Russell Johnson Mood 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Patricia L. Buckler/Daughter P.O. Box 434, Leonardtown, MD 20650 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl ■ Burial 2 ☐ Cremation 3 ☐ Removal from State Charles Memorial Gard. 12/30/2011 4 Donation 5 Other (Specify) Leonardtown, MD 2 Name and Address of Facility Mattingley-Gardiner Funeral Home, 41590 Fenwick St. Leonardtown, MD 21 Signature of Funeral Service Licens farcline 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) 3 Miles Physician/ THORACIC Medical Due to (or as a consequence of) Examiner 14 MONTHS METASTATIC Sequentially not conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: NA A-23b. Was decedent pregnant use yes, outcome of pregnancy 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No for Pregnant at time of death Month Year detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law page 2 autopsy performed' within 24 hours after death.

To the Funeral Director; After this certificate 1 Yes 2 No Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 **N**No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending Investigation
6 Could not be 1 ☐ Yes 2 ☐ No Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) the 29b. Signature and 30. Name and ad on who completed cause of death (Item 23a) (Type, Print) 5) Eml KHAN, 25500 POINT LOVERT Rd. HOSPITAL

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

DEC 28 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Date Month 3 Physician/ 0744 TO Trevor L. Wynter Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City. Town, or Location of Death 4c. County of Death MADICAL 101M100 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Months Days Min (Month, Day, Year) Director 218-58-0810 1**X** M 2 □ F 56 0 - 23 - 1955Usual Residence of Decedent MD show 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f 1 Yes 2 X No MD Wicomico Salisbury 10e. Street and Number items 23a or ner must be n ò 10f. Zip Code 10g. Citizen of What Country? Funeral 1701 Samuel Lane 21801 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ō þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: SpecBlack "natural" Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) If Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the 12 Supervisor Salisbury Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Dudley Wynter Ruby Deal and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health tem 27 Leona Y. Wynter/Wife Samuel Lane, Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o cemetery, crematory or other @ard 1 X Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Spring Hill Mem 12-17-2011 Hebron, MD 21. Signature of Funeral Ser 22. Name and Address of Facility Bennie Smith Funeral Home 917 W. Isabella St. Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed y physician and as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as the ed by the attending | detached for use as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Day Month signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License number

State Registrar 31. Date filed (Month

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend#2 per PHY. State of Maryla StateAACO HEATTH DEPT. CMH 12/14/2011 State of Maryland / Department of Health and Mental Hygiene 42554 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 10 3. Time of Death Lucia P. Welch Physician/ Month 8:50 A December 2011 Medical 4a. Facility Name (if not institution, give street and number)
Mallard Bay Care Center 4b. City, Town, or Location of Death Cambridge **Examiner** Dorchester Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Dec. 13. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 579-40-7553 1 🗆 M 2 🗓 F Months Days Hours 79 Country) Washington. **Director** Dec. Usual Residence of Decedent ms 23a or 28a-f shov must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Funeral Director Maryland Talbot Easton 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21601 105 Parris Lane USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cashier Grocery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Albina Antorchelli John Giliotti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela M. Lewis/ Granddaughter 105 Parris Lane, Easton, Md. 21601 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Lakemont Cemetery 12-15-2011 Davidsonville, Md. 21. Signature of Funeral Service Cense 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, Md. 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Provictant 6 UPAC Medical Examiner Sequentially list conditions, if any leading to innecled cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last and the burial-trai Due to (or as a consequence of) ed by the attending physician detached for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: use yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Day Month Year Yes within 24 hours after death.

To the Funeral Director: After this certificate has been signed by completed filled in by the funeral director, page 2 should be detact Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given i**ŋ** Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 100 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2 \square No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and itle of certifier 29d. Date signed ddress of person who completed cause of death (Item 23a) (Type, Print) 00 Day, Year) 1 4 2011 Registrar's Signatu State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dorothy Mary Ward 13,2011 12:20 A M December Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Tate Hospice House Linthicum Anne Arundel 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Hours (Month, Day, Year) **Director** 220-14-2772 1 M 2XXF 85 Vrc 05/20/1926 Baltimore, MD Usual Residence of Decedent 28a-f show 10c. City, Town or Location or items 23a or 28a-f sho miner must be notified at 10d. Inside City Limits Director MD 1 Yes 2 No Anne Arundel 0denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2522 Black Oak Way 21113 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, other traumatic event, the Medical Examiner Armed Forces No Black, White, et 1 Never Married 2 Married ğ Maryland 21215-0036 hours after 1 ☐ Yes 2 No Specify. White If Yes, Give Year or Dates 3 X Widowed 4 ☐ Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Own Home Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker UNK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Chester Stella 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is William Robert Ward 2522 Black Oak Way Odenton, MD 21113 Son Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State any injury or Dulaney Valley 12/15/2011 Timonium, MD 4 Donation 5 Other (Specify) Signature of Fund Service License 22. Name and Address of Facility Hardesty Funeral Home P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death erebrorescular Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner spestens, on Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examir Hyper / Dem, q nding physician and use as the burial-tran that initiated events resulting in death) Last Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗓 No for Month Year Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Fibrillerion Records, 1 Yes 2 No 3 Probably 4 Unknown Completed orany Artery Disease 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) 24a. Was an page 2 autopsy Yes To the Hospital or Attending Physician: director, 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 & Other (Specify) 4050 ite 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No 5 Pending Accident Investigation 6 Could not be Suicide nt. 24 hour. Se **Funeral Dir.** Vifilled in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check 29b. Signature nd title of certifier 0005-2089

State Registrar 31. Date filed (Mor

DEC 1 4 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2401 Brandermill Boulevard Suite 220 Gambrills, MD 21054 Ruth K. Gallatin, M.D.

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1^{Month} -07^{ay} $20^{\circ}1^{\circ}1$ Mary Nadine Weaver 0915 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 24360 Widgeon Place Unit # 12 Talbot St. Michaels 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8 - 27 - 1924 Birthplace (State or Foreign Country)

Md. 6 Sex 7. Age (In yrs last birthday) **Funeral** 1 D M 2 XF Days Hours Min. 219-10-0488 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location at 10d. Inside City Limits within 72 hours after death with the Maryland Director iral", or items 23a or 28a-f s Examiner must be notified Md. Talbot St. Michaels 1 🗆 Yes 🚈 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 24360 Widgeon Place Unit # 12 21663 U.S.A.12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White If Yes, Give Year or Dates 3 XWidowed 4 ☐ Divorced Specify: "natural" Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Frederick W. Nadine Lotz C. Waltz 19a. Informant's Name/Relationship (Type, Print)
Bruce D. Weaver / Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6252 Blooming Grove Road, Glenville, PA. 17329 20a. Method of Disposition
1 □ Burial 2 🎖 Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date crem. of De Imarva 12-8-2011 Delmar, DE. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Rutteyd &dostrowski Funeral Home P.A. sough M. Osteonshi C.f.S.P P.O. Box 518 St. Michaels, Md. 21663 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ allure disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner arcinoma Sequentially list conditions Examine cause. Enter Underlying and transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): burial nding physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Day Year Pregnant at time of death signed by the a Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Pulmoreu Obstructure 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 autopsy performed? Yes 2 X No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending To the Hospital or Attendia within 24 hours after death. To the Funeral Director: At completed filled in by the fu Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

State Registrar

Medical

29a. Certifier

(Check only one)

31. Date filed (Month

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DEC 0 8 2011

Russell A. Schilling D.O. 555 Cynwood Drive, Easton, Md. 21601

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

H42581

29d. Date signed (Month, Day, Year)

12-08-2011

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Funeral Director		5. Social Security Number 236-64-8128	6. Sex	7 M 2 💢 F	. Age (In yrs. la		If Under 1 Year Months Days	If Under: Hou <i>r</i> s	24 H <i>r</i> s Min.	8. Date of Birt (Month, Da	th y, Ye <i>ar</i>)	g.	Birthplace (State or Foreign Country)		
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2 hours after death with the Maryland "natural", or items 23a or 28a-f show edical Examiner must be notified at		3 Widowed 4 D		If Yes, Give Year or Date		1	☐ Yes 2 💢 No	Specify:			s	pecify:	Wh	ite	
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ould b		Joseph Her 19a. Informant's Name/Re				19b. Mailin	ng Address (Street a			Ruth F			. Zip C	ode)	-
nd 2 sh ealth a nn 27 is ertrau		Ronnie L. W	Veese/Hu	sband			. 1, Box			Garden					
ge 1 ar nt of H if iter or oth		20a. Method of Disposition 1 🏿 Burial 2 □ Crei	mation 3 🗆 Re	emoval from S			sition (Name of natory or other plac	e)		Date	20c. Loc	cation - City	y or To	wn, State	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inpartment of Health and Mental Hygiene. Inpartment of the material and Mental Hygiene. any injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 0		/	<u>Ka</u>		Cemetery . Name and Addres			29,201		Elk Ga In Sti		en, WV	_
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To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. Within 24 hours after death. To the Luneral Director. After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burian	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)									23d. Date of delivery Month Day				
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To the Hospital or Attending Phyminin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral	d Certificate:	3 ∐ Suicide 6 ∐	Could not be determined		f Injury - At ho g, etc. (Specify		eet, factory, office			28f. Location (S City or Tow		Number or	r Rural :	Route Number,	_
he Hospit in 24 hour he Funera pletely fill	Medical	(Check 2 🔲 Me	edical Examine	: On the basis	of examination	and/or invest	occurred at the time tigation, in my opinio death occurred at the	n, death oc	curred at	the time, date a	and place, a	and due to	the cau	ise(s) and manner stated	d.
Not A vith		29b. Signature and little of	certifier d	0 (Pode	-	29c. License		2		29d. Date	signed (M	onth, E	lay, Year)	
O Die.		30. Name and address of p		•			rint) vbrook Ro	ad C	nmh -	rland	MD	21500	,		
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11-09662

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Peggy Yeager State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day December 24, 2011 **Medical Examiner** 1950 hrs Peggy Sue Yeager 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 23285 Point Lookout Road Lot E St. Mary's Leonardtown 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** 7. Age (In yrs. last birthday) Foreign CountryMaryland Director Months Days Hours 53 1 M 2 X F 219-78-0739 Yrs 01/13/1958 Usual Residence of Decedent 10b Count 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No with the Maryland Leonardtown Marvland St. Mary's Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? USA 23285 Point Lookout Road Lot E 20650 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 1 Never Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. hours after death 2 Married 2 X No Yes 3 Widowed 4 Divorced Yes, Give Year 1 Yes 2 No specify: Specify: White than "natural", 2 Pages I and 2 should be filed within 72 hours rent of Health and Mental Hygiene. nut: If item 27 is marked other than "naturn or other traumatic event, the Medical Examin 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Grocery Store Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Betty Moore Rex Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23285 Point Lookout Road Lot E Leonardtown, MD20650 <u> Clarence R. Yeager, Jr./Son</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place)
Mattingley-Gardiner Burial 2 Tremation 3 Removal from State 4 Donation 5 Other Specify Leonardtown, MD Funeral Home Crematory 12/30/2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, 1 41590 Fenwick St., Leonardtown, MD retract 23a. Plant I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or es e consequence of): if eny, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical X UNPENDED AMENDED 23a, 27, per me, $g_{923} 1-12-12 \text{ sm}$ attending physician for use as the burial -O. Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 ✓ Unknown 9 Unknown ned by the a detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≦ Records. P. 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has l death? certificate l rector, page ✓ Yes 2 No 1 🗸 Yes After this certific funeral director, p the Hospital or Attendiog Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene 1 🗸 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 📉 Natural Pending Director: d in by the f 1 Yes 2 No hours after death. 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be within 24 hours af

To the Funeral D

completely filled i or Town, State) determined 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E December 25, 2011 30. Name and eddress of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) Registrar's Signetu

DHMH 17 Rev 1/2001 **OCME 2006**

State Registrar

ÖRIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 50 PM Physician/ Cheryl Renee Young 2011 December Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Mary's St. Loveville 40488 Beatrice Lane 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) . Social Security Number **Funeral** Months Hours 5/09/1966 Country) MD 1 🗆 M 2 🛣 45 Director 213 90 6348 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a. State 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at death with the Maryland Director 1X Yes 2 ☐ No Loveville St. Mary's MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20650 Funera USA 40488 Beatrice Lane 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status the Medical Examiner Armed Forces?
1 ☐ Yes. 2 🔀 No
If Yes, Give Black, White, etc. ō 1 Never Married 2 Married δ permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: Black Completed 3 🗌 Widowed 4 🗌 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) School 12th Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Viola Cecelia Dickens မ Joseph Wallace Young, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 40488 Beatrice Ln.Loveville, MD 20650 Viola C. Young/ Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Queen ofPeace Cem. 12/20/2<u>011 Helen, MD</u> 22. Name and Address of Facility Briscoe-Tonic Funeral Home . Signature of Funeral Service Licensee 2294 Old Washington Rd. Waldorf, MD 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final MEIASTATIC BREAST CANCOR Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Physician/Medical Exami executed anding physician and use as the burial-transil that initiated events Due to (or as a consequence of): resulting in death) Last the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Live Sirth 2 Pregnant at time of death Month Day Year 9 Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopu performed: 2 N page 2 s 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To this 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at s after death.
Il Director: After the od in by the funera work? 1 ☐ Yes 2 ☐ No injury 1 Natural 5 Pending Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completed Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) within 2 29d Date signed Month, Day, Year 29b. Signature and ti 12011

State Registrar ST. MARY'S HOSPITAL, 25500 KINT

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. 3

KHAN

31. Date filed (Mon

8846

LOOKOUT

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LEONARD TOWN, MID - 20650

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
Amend 23e per DVR G923 1/5/12 GR
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Effie Amprazis Zuck Physician/ Month Dav Year 1:02 A.M 2011 Dec Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c, County of Death **Examiner** Westminster Carroll Hospital Carroll 8. Date of Birth (Month, Day, Year) March 18,1934 9. Birthplace (State or Foreign Country) Greece Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. **Funeral** Days 1 □ M 2 🕅 F Hours 77 Director 215-34-5155 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits aţ Director Examiner must be notified State College PA Centre 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ь 10g. Citizen of What Country? 23a Funeral USA 16801 374 Meckley Road items Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Race - American Indian Black, White, etc. P \$ 1 Never Married 2 X Married 1 Yes If Yes, Give 72 hours after 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural" 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the N 12 Master Gardner Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Aristidis Amprazis Vasiliki Tsaknis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Eldred Zuck 374 Meckley Road, State College, PA 16801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Boalsburg Cemetery Dec. 10,2011 Boalsburg, PA 21. Signature of Fundal Stivice Li ensee 22. Name and Address of Facility State College, PA 16801 lens Koch Funeral Home, 2401 S. Atherton St. 23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each light the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) burial-transi that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death 1 Yes 2 2 🔀 No 9 Unknown signed by t use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacc Completed by STOLIC CONGESTIVE HEART FAILURE Division of Vital Records, 3 Probably 4 Unknown page 2 should peen RDIO MYOPATAY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perforn SHEONIC KIDNEY & Hospital or Attending Physician; The 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 KNo dire မ 1 Inpatient 2 KER/Outpatient 3 IDOA this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No 5 Pending injury Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Praction of Talks Costs of the Costs o (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) 200 SCENERY DRIVE STATE COLLEGE, PA1689) State

DHMH 17 Rev 7/2009

Registrar

NATIVILY (ONXAKNO) VIVILAND

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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day lonth Physician/ 6-30 201 Medical 4b. City, Town, or Location of Death 4c County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Kaven 60 8. Date of Birth (Month, Day, Year Nov 22, 1 9. Birthplace (State or Foreign If Under 1 Year Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. Funeral Min. Hours 1 👿 M 2 🗆 F Months Davs Maryland 1946 Nov Director 214-46-7930 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event the Marker. 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County Director 1 Yes 2 No Baltimore MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 21234 8720 Emge Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Completed by 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates. Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 💢 No Specify: 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Şeconday (0-12) transportation truck driver Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ June Marie Hubbard Earl Robert Aro 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 120 Tudor Court Malvern, PA Robert Aro Jr/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 ★ Other (Specify) in state Signature of Phonal Some Licens a State Anatomy Board Baltimore,MD 21201 655 W. Baltimore Street Enter the disease, or complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence oi). eeral Director. After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗌 Yes 2 🛭 No 2 📈 No Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical Other 1 Yes 2 No မ ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 1 Inpatient 2 I 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 2 No 1 🗌 Yes death. Accident Investigation 24 hours after deat Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifie Kray! address of person who completed cause of death (Item 23a) (Type, Print) Name ROCKVILL 31. Date filed (Month, Day, State 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6:52 PM Dec Bentfeld. ľŠ Gary Bert 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE HOSPITAL OF BALTIMORE 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr. 8, 1947 Funeral Sex 1X M 2 □ F Age (In yrs. last birthday 9. Birthplace (State or Foreign Days Months Hours Min. Country) **Director** Ohio 64 Apr. , or items 23a or 28a-f show miner must be notified at 10a State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits OH Mahoning New Middletown 1 X Yes 2 No 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 37 Sycamore Drive 44442 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit, Page 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner I 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married þ Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 ☐ Widowed 4 ☐ Divorced ır yes, Give Year or Dates. Vietnam Yes, Give White Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Assembler Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ethel Leona Charles Kenneth Bentfeld 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Erleñe Bentfeld - Wife Sycamore Drive, New Middletown, OH Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specific Petersburg Cemetery Dec. 23,2011 Petersburg, OH 22. Name and Address of Facility Terry A. Cunningham Funeral Home 203 Oak St., Bessemer, PA 16112 21. Signature of Funeral Service Vicense un 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Caro ASSOCIATED meunong disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of Cause (Disease or iinjury that initiated events burial-tra Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 5 Other (specify) Month Year detached 9 Unknown Unknown q Arrer this certificate has been signed in funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ADS Completed 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy death? 2 1 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital မ 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manne of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work' 1 Yes 2 No Accident Investigation 24 hours after deat Funeral Director: Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie (Check To the within 2 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. 8Ignature 29c. License number D69656 DEC. 18,2011 12 Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 NV Belvedere ave Baltimore MD 21215 egistrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Bever 2:00 P M Medical ot institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner ou thland Awi Baltimore Kuad Va Inn 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours Min. Country) 1 🗆 M 2 🐼 **Director** Usual Residence of Decedent 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21207 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ò 1 Never-Married 2 Married ģ Baltimore, Maryland 21215-0036 1 Yes 2 No permit. Page 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Specify: Blac Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) secia Father's Name (First, Middle, Last) Be 18. Mather's Name, (First, Middle, Maiden Surname) Sewell ပ္ iam Berery 19a. Informant's Name/Relationship (Type, Print) Rural Route Number, City or Page 1 and 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Date 1 🗹 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) -2012 Signature of Funeral Service Licens 21 Services Funeral Road Randa MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line e of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) 400 Medical Due to (or as consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
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**Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Descritifying Physician: To the basis of examination and/or investigation." Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one) 29b. Signature and title of 29d. Date signed (Month 0 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 6 Registrar

Brown

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

amend #1 per PHY Per ANA BD G923 1/06/2011 H
State of Maryland / Department of Health and Mental Hygiene 0 1 1 4 2 5 6 5

				Cer	tificate of	Death		Re	g. No.	1 1	72000	
		Decedent's Name (First, Middle, Last,		n .				2. Dete of Deeth Month	Dev	Year	3. Time of Death	
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Examine	4 -	Fecility Neme (If not institution, give	street end number)			4b. City, To	wn, or Lo	cation of Deeth		y of Death		
		North Hampton N	ursing Hom	e						deric		
Funeral	5.	Social Security Number 201 6. Se	7. Age (/	n yrs. last birthday)	If Under 1 Year Months Days		Min.	8. Date of Birth (Month, Dey,	Yeer)	9. Birthp	place (Stete or Foreign	
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hou hou like kill kill kill kill kill kill kill		9a. Certifier (Check only 2 Medical Exam	eiclan: To the best of r	ny knowledge, death	occurred at the	time, date a	nd place	, and due to the o	euse(s) and	manner es	stated. to the cause(s)	
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Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible amend #20b&c Per FH 6923 1/05/201 In JH State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Physician/ 201 rne Medical 4b. City, Town, or Location of Death County of Death 4c. Facility Name (if not institution, give street and numb **Examiner** birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months (Month, Day, Year) Country) **Director** 1 □ M 2 ₩ Yrs. an permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 No mar 10g. Citizen of What Country? 10e, Street and Number Funeral 7:20 р.ш. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in 12. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) most of working Elementary/Secondary (0-12) College (1-4 or 5+) Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ၉ DECEMBER 26, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z Code) Informant's Name/Relationship (Type, Print) 0 Hasá ²⁰**Wood Lawn**or Town, State 20a. Method of Disposition 200 Place of Disposition (Name 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Funeral Service Licenses Signat 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ RENAL DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Examiner Due to (or as a consequence of) burial-transit executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ate has been signed by the atterprage 2 should be detached for a in the past 12 months?
1 Yes 2 X No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown DORIS COLLIER Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perforn death? within 24 hours after death.

To the Funeral Director. After this certificate handletely filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6X Other (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 X No မ 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 🗶 Natural 5 Pending 2 No М Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Defining Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| We certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of 201 son who completed cause of death (Item 23a) (Type, Print) 30. Name and add MD 21093 2300 DULANEY VALLEY RD. TIMONIUM, JONES, CRNP JACKIE Registrar's Signature State 2012

Registrar

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2011

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ December ark Medical 4a. Facility Name (if not institution, give_street and number) 4b. City, Town, or Location of Death **Examiner** 9/MADE 6 Sex If Under 24 Hrs. 8. Date of Birth Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours Min (Month, Day, Year) 10/08/195 215 70 3859 1 🕱 M 2 🗆 F 56 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City, Town or Location Director N/A Marvland Baltimore 10e. Street and Number 10f. Zip Code Funeral 21225 3 Washburn Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Medical Examiner 1 Yes 2 X No If Yes, Give Year or Dates. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🕱 No Specify: "natural", 3 Widowed 4 X Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) 9th College (1-4 or 5+) Installer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Charles Clark Betty Rathell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Whiteford / sister 43 Carroll Road Pasadena, Maryland 21122 20a. Method of Disposition 20b Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 01/03/2012 Bavview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 4001 Ritchie Highway 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ 40ca-dia disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examir Physician: The law requires that the death certificate be executed the burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? jo Pregnant at time of death signed by the a 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, Jas page 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) funeral director, Hospital: 1 Yes Other: 2 | No 1 Inpatient 2 ER/Outpatient 3 IDOA ဂ္ 28a. Date of injury / (Month, Day, Year) 27. Manner of Death 28b. Time of e Hospital or Attending Pl 124 hours after death. e Funeral Director: After the pleted filled in by the funera 28c. Injury at Certificate: Natural 5 Pending 1 Yes 2 No Accident 3 Suicide Investigation 6 Could not be thin 24 hours after de the Funeral Directo mpleted filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check

30. Name and address of person who completed cause of teath (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

20c. Location - City or Town, State Baltimore, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A. Baltimore, Maryland 21225 Approximate Interval Between Onset and Death week 23d. Date of delivery Month Day Year 23e Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Yes 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Greatifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) Manover Street Balhaure MO 21225

2011

N/A

9. Birthplace (State or Foreign

10d. Inside City Limits

1 X Yes 2 No

Country) PA.

White

Chesapeake Sprinkler

4c. County of Death

10g. Citizen of What Country?

16b. Kind of Business Industry

14. Race - American Indian,

Black, White, etc.

U.S.

Registrar DHMH 17 Rev 7/2009

State

within 2 To the I

only one)

29b. Signature a

Kobe

South

29c. License number

D0052022

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20**11** Mary Catherine Corderman December 12:48 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Calvert Manor Nursing Home Rising Sun Cecil If Under 1 Year If Under 24 Hrs 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Oct. 20, 1 M 2 1 Months Days Hours Min. Maryland 218-24-1967 94 **Director** 1917 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Maryland Cecil Rising Sun 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? ò "natural", or items 23a o dical Examiner must be Funeral 1881 Telegraph Road 21911 USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black. White, etc. ş 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 X Divorced Completed White and Mental Hygiene.

is marked other than "natural raumatic event, the Medical" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) within 7 Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Clarence Albert Frush Anna Viola Hull Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Ann C. Helton / Daughter <u>3069 Harmony Church Road, Darlington, MD 21034</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ☐ Burial 2 X Cremation 3 ☐ Rer m State oval f Hilltop Service Corp 1-5-2012 Towson, Maryland onation 5 Other (Specify) 22. Name and Address of Facility McComas Funeral Fome, P.A. are of Funeral Se 21. Sig 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Fart 1. Enter the disease, or сопрысаются shock, or heart failure. List only one cause or art 1. Enter the dis that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death each line Immediate Cause (Final Of Alzheimer's Physician/ Amontia, disease or condition resulting in death) Man Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence on burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Por in the past 12 months?
1 Yes 2 No Month Dav 5 Other (specify) Pregnant at time of death Yes 4 ☐ Pregnant s been signed by the same should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? +06 Cerehra Vascu 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has page 2: autopsy Yes 2 XNo certificate funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 WNo Hospital: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural work?
1 Yes 2 No 5 Pending 24 hours after death. Funeral Director: A Investigation Accident completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 12 MO . Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day,

Rising Sun, MD

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Regist

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Margaret L. Curran 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death timore HOSDITA **Funeral** 9. Birthplace (State or Foreign Country) New Jersey 8. Date of Birth 1 M 2 X F Months (Month, Day 20 Days Hours Min. Day, Ye **Director** 52-32-5512 1942 May Usual Residence of Decedent is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at 10a. State 10b. County death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits MD 1 ☐ Yes 2 X No Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1300 Windlass Drive 21221 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Page 1 and 2 should be filed within 72 hours after or thent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Completed by 1 Never Married 2 Married timore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. 3 Widowed 4 Divorced Specify: white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry unk (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) housekeeping 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph Curran Rita Mary Trainor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4 Cool Breeze Drive Middle River, MD 21220 Rita Zaragoza/sister 4 Cool Breeze Drive Middle River, MD permit. Page 1 and 2 Department of Health Important; If item 27 any injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🗓 Other (Specify) in state Signa or Fineral Sirvice i censee State Anatomy Board 655 W. Baltimore Street MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or 's a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of Exam been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy performed? 1 Yes 2 No To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h death? 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To 1 🗌 Yes 2 No Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tițle of certifier 29c. License number n we 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 anklin 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

11-09123
Lori Clough

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. For State Reg. No Registrar 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day December 4, 2011 1121 hrs **Medical Examiner** Lori Clough 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Wicomico Fruitland 400 St. Lukes Road If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** oreign Country)Maryland Months Days Hours Sept 15, 1976 Director 35 220-96-3444 2 **X**F 1 M Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 X No Fruitland MD Wicomico or 28a-f show notified at once. death with the Maryland Directo 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number USA 21826 400 St. Lukes Road 238 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 11 Marital Status 12. Was Decedent Ever in U.S. White, etc. Armed Forces 1 Never Married 2 X Married 2 X No Yes 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: permit, Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", o injury or other traumatic event, the Medical Examiner in injury or other traumatic event, the Medical Examiner in injury or other traumatic event, the Medical Examiner in injury or other traumatic event, the Medical Examiner in injury or other traumatic event, the Medical Examiner in injury or other traumatic event, the Medical Examiner in injury or other traumatic event. white 3 Widowed \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 healthcare traveling paramedic 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William E. Webster CArolyn M. Rash 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MDMike Clough/spouse 400 St. Lukes Road Fruitland, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a, Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other, Specify: in
21. Signature Funeral Sprice Sicen ex 22 Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director Raltimore, MD 21201

23a. Part I. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line Microical Death a Methadone Intoxication Immediate Cause (Final disease Ėxaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical AMENDED23a,pt.II,27,28a-f,per me,g923 1-18-12 sm X UNPENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown the a 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. signed by t Part II. Other significant conditions à 1 Yes 2 No 3 Probably 4 Unknown Atherosclerotic cardiovascular Disease Completed 24a. Was an 24b. Were autopsy findings available s been s prior to completion of cause of autopsy performed certificate has death? ✓ Yes 2 No 2 No page 1 🗸 Yes 26.Place of Death (Check only one) e Hospital or Attending Physician: 124 hours after death.
e Funeral Director: After this certifictely filled in by the funeral director, 25. Was case referred to medical Be examiner? Other4 Nursing Home 5 Residence 6 ✔ Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 27, Manner of Death Certification: Natural 1 Yes 2 No unknown 5 Pending fd11:02 am fd 12-4-11 Accident Investigation 2 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be Suicide 3 or Town, State) 400 St. Lukes Rd. determined Found: Residence Fruitland.Md Homicide 29a. Certifier 1 within 24 ho

To the Function Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier December 5, 2011 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Laron Locke MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year)
JAN 0 6 20 32. Registrar's Signature

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Division of Vital Records, rat or Attending Physician: The law requirer ster effort. 1 Director: After this certificate has been siled in by the funeral director, page 2 should be after a fire of the control of the												auto		pr		opsy finding impletion of	
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FVi Physi er this	2	1 ✓ Yes 2 No 27. Manner of Death			Inpatient e of Injury		ER/Outpatient			y at Work?		28d. Describe				Scelle	
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Division O Hospital or Attending 24 hours all or Attendent Funeral Director: Aftered filled in by the fune		- Juicide - Jui	rmined	(Specify	1)						ŀ	or Town,	State)				
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To the Hos within 24 h To the Fur completely	2 L	~ 🖳		On the basis and manner		iiiation ai	nd/or investiga			number	AII BU BI	ane ume, date		. Date signe			r)
	-	29b. Signature and title of certifi		/	~		10	290	O.C.N				1	cember	•		,
	-	30. Name and doff s of person	who c	ompleted ca	use i de	ath (Itèm	23a)										
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			1 - For State Registrar	State of Maryla		artment of F			ene 2 0	1 42572
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	Physic		Joseph Le	e Cline	5 SV	•		nec 3	Day Yee	- 2 - 11
Jane 1	/Medi Examir		4a. Facility Name (If not institution, give			4b. City. Town, or	r Location of Death	Dec	4c. County of De	
	Exami	iei	100 Govenors Court			Glen Bu			Anne Aru	indo1
	Funeral		5. Social Security Number 6. S		. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9.6	Birtholace (State or Foreign
	Director			M 2□F 66	Vre	Months Days	Hours Min.	(Month, Dey, Y		Country) arvland
			Usuel Residence of Decedent				1	1/1/15	7 110	i j zana
	ylan		10a. State 10b. County	10c. C	City, Town or Lo	ocation				10d. Inside City Limits
	Ma-1-e	Ş	MD Anne Art	ındel	G1	en Burnie				1 ☐ Yes 2 No
	h the	Director	10e. Street and Number			10f. Zip Code		10g	g. Citizen of What	Country?
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	deal	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H	ispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No-		merican Indian,
ထ	after or Ite	E	1 ☐ Never Married 2 ☐ Married	1,⊠Yes 2 □ No		1 ☐ Yes 2.26 No	Specify:	nican, etc.)		nite, etc.
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ις.	72 h natu disal	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Give	dent's Usual Occup	during most of worki	ina 16	b. Kind of Busines	ss/Industry
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밀	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "natural", or Itama 23a or 28a-f ehow event, if a Mudisal Exarters rutal be notilised at	Be	17. Father's Name (First, Middle, Last)					(First, Middle, Ma	uiden Sumame)	
$\frac{8}{8}$	should ind Men marke	ုင	Eli T. Cline					rine K.		
-	2 sho	8	19a. Informant's Name/Relationship (**			and Number or Rura			
	ss 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene . Item 27 ie merked other then "natural", or Itama 23a or 28a-1 ehow titem 27 ie merked other then "natural", or Itama Lie notified at rother treumatic event, Ira Mudical Exart natural Lie notified at	1 3	Helen V. Yarbor /	Companion	-					, MD. 21061
altimore,	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	cemetery, crei	osition (Name of matory or other place	(e)	Date 20	c. Location - City	or Iown, State
Ξ	Pag Iment tant: I		* 4 ☐ Donation 5 ☑ Other (Specify				ery 1/5/			, Maryland
Ball	permit. Pages Department of Important: If i eny injury or once.		21. Signature of Funeral Service Liter	see			ss of Facility Lou			
	<u>0</u> 05 € d	1	(ugen	Car M			ns Ave.			and 21229
			23a. Part1. Enter the disease, or con- shock, or leart failure. List only	plications that caused the decone cause on each line.	ath. Do not ent			or respiratory arrest	t,	Approximate Interval Between Onset and Death
Ù	hysician		Immediate Cause (Final disease or condition	a Blad	der	Cano	ev			4 Veurs
	/Medical Examiner		resulting in death)	Due to or as a conse	quence of):					
		L	Sequentially list conditions,	b						
34	sit s	ine	if any, leading to immediate cause Enter Indentying Cause (Disease or injury	Due to (or as a conse	quence ot):					
	and and I-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conse	ouence of):					
8760,	s be executed sician and burial-transit			506 (0) 63 2 00136	querice or).					
8	the the	dlcal		d						1
×	eath certific attending p for use as	Physiclan/Me	IF FEMALE:	23c. If yes, outcome of pregr	nancy					
Rox	ath cer attendir for use	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fe	tal death 3	Ectopic pregnancy	•		23d. Date of o	delivery Day Year
o	the de	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐ Pregnant at time of 9☐ Unknown	death 5	Other (specify)				
٦.	The law requires that the de ste has been signed by the a page 2 should be detached to		Part II. Other significant conditions c	ontributing to death but not re	sulting in the u	ndertving cause give	en in Part I.	23e. Did tobar	cco use contribute	to the cause of death?
g	sign sign d be	d by	Fritestin	al Ilpa	S	, ,		1 ☐ Yes	2 No 3	Probably 4 Donknown
Ö	w require been sig should b	ete						-	_	
<u>ě</u>	The law cate has page 2 s	Completed						24a. Was an autopsy performe	prior	autopsy findings available to completion of cause of
									No 1 Y	es 2 No
Vital Records,	Attending Physician: The death. ector: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth-	er	(Check only one)		-
ō	Phys this aldii	. To	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatier	IT 3L DOA	4 Nursing Ho	me 5 Resident		pecify)
	ding f	lo lo	1 D Natural 5 ☐ Pending	(Month, Day Yeer)	28b. Time o Injury	Worl		28d. Describe how	injury occurred	
DIVISION	offer of death ctor: /	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		homo form at		Yes 2 □No	20f Location /Stro	of and Number of	Rural Route Number.
2	or Attendated Director:	ertif	4 Homicide determined	28e. Place of Injury · At building, etc. (Spec	ofy)	eet, factory, office		City or Town,		Aurai Aobie Number,
_	Hospital or At 24 hours after o Funeral Direct etely filled in by		29a. Certifier 1 certifying Ph	veician: To the heat of miles	nowledge de-	h conversed at the c	on date and -l	and due to the	00/0/ 0-1	as stated
	Fun Fun Hely	edical	(Check only 2 Medical Exam	ysician: To the best of my kr iner: On the basis of examir and manner stated.	nation and/or in	vestigation, in my o	pinion, death occurr	ed at the time, date	e and place, and d	as stated. lue to the cause(s)
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifier	- /		29c. Licensi	e number	29d	1. Date signed (Mo	onth, Day, Year)
4	F 3 F 8		Palmer (01	asti ni	\supset	Don	01459	3 0	and :	2012
			20 Name and address of	completed cause of death (the	am 22a) (T	Drint)			2 (1112	
XI			30. Name and address of person who	completed cause of death (Ite	511 23a) (1ype,	Ditala	10 Kl.	Lugar		
	Sta	te	31. Date filed (Month, Day, Year)	3. Registrar's Sign	nature	121/00/1	17/	N ~ ~		
	Registr		LANTO 6 20	1/2 Deced	A. Da	Mark	N	1.1	11/	1776

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 State of Mandand 1 Penant of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Cohen Physician/ 20 44 M Claude December 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** The Johns Hospital Ltor kins Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Nov. 16, Hours Year 217-26-9966 81 1930 Mary Tand Director 1 🔼 M 2 🗌 F 28a-f shov 10a. State 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 🗆 Yes 2 🔀 No Ellicott City MD Howard o 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 2677 Legends Way 21042 USA death Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. nd Mental Hygiene. marked other than "natural", or þ 1 Never Married 2 X Married 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Completed other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) BG&E Management Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H Cohen Josephine Claude 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl ment of Health a 7205 Tall Pine Way, Clarksville, MD 21029 Steven Cohen (Son) 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Cemetery 12/19/11 20c. Location - City or Town, State ö 1 X Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If Baltimore, Maryland injury 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home any 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheek, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Myocardial Medical Due to (or as a consequence of) Examiner ntacrania Sequentially list conditions, Examine it any, leading to immediate cause. Enter Underlying Due to (or as a conseduence of CERTIFICATION APPROVED BY MEDICAL EXAMINER Cause (Disease or injury inding physician and use as the burial-tran that initiated events resulting in death) Last $\#\mathcal{Z}_{\mathcal{A}}+\mathcal{I}$ $\mathcal{T}_{\mathcal{A}}$ $\mathcal{T}_{\mathcal{M}}$ Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown for Month Year Pregnant at time of death Day the hed ed by the signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Yunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has to page 2 s performed? certificate 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 X Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending s after death.

I Director: A do in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after To the Funeral Direc completely filled in by determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Fractitioner: To the best of my knowledge And the bride 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES-000 December 13 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe Street Baltimore, MTD 2128 Greenberg

State Registrar 31. Date filed (Month, Day, Year) JAN 0 4 2012

Registrar's Signature

Lewis Drayton
11-08801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Dhysisian		egistrar 1. Decedent's Name (First, Middl	e.Last)						2	2. Date of Deat	h		3. Time of Death
Physician Medical Examine	4	Lewis Drayt								Month November	Day Ye 22, 2011	ar	1359 hrs
,		4a. Facility Name (if not institution		number)		4b. City	Town, or L	ocation of	Death		4c. County	of Death	
		5400 Block of Californ	ia Avenue			Balt	imore						
Funeral	!	5. Social Security Numberink	6. Sex	7. Age (In yrs.	last birthda	y) If Un	der 1 Year	If Under	24Hrs.	8. Date of Bir	th(MM/DD/YYY	Y) 9. Birtl	nplace (State or unk
Director	1	dilk	1∑M 2_F		65	Yrs. Mon	ths Days	Hours	Min.	June 2	24, 1946	Foreign	n intry)
	H	Usual Residence of Decedent	121VI 2 1	J.,		110.			l				
k w	-	10a. State 10b. County		10c. Cit	y, Town or l	ocation							10d. Inside City Limits
		MD			Balt	imore							1 X Yes 2 No
rylan	밁	10e, Street and Number				10f. Z	ip Code			1	0g. Citizen of W	hat Coun	try?
death with the Maryland ritems 23s or 28s-f sho must be notified at once.	2	3800 W. Belv	edere Av	enue			2	1215			Ţ	JSA	
ith th	_	11. Marital Status	12. Was 0	Decedent Ever in I	J.S. 13	3. Was Dece	dent of Hisp	anic Origin	1? (Spe	cify Yes or No	- 14. Rao	e - Americ	an Indian, Black,
r death with or items 23 must be no		1 Never Married 2 M	arried Armed	Forces?	unk	If Yes, spe						te, etc.	
rer de		3 Widowed 4 Div	orced If Yes, Give		1.	1 Yes	2 X No	specify:			Specify:	b1	ack
furial 4	<u></u>	15. Decedent's Education (Spe	or Dates:								16b. Kind of B	usiness/Ir	ndustry unk
2 ho	отріете	Elementary/Secondary (0-12)	College	(1-4 or 5+)	- duri	ing most of w	orking life.	DO NOT u	se retire	a)			
thin the reflict	ğ	unk	unk		1								
other M	5	17. Father's Name (First, Middle	, Last)	*-		u	nk 1	8.Mother's	Name (First, Middle, I	Maiden Surnam	е)	unk
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MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland lib and Mental Hygiene. In 27 is marked other than "natural", or items 23a nr 28a-f she numatic event, the Medical Examiner must be notified at once TO Bo Compileton by Ermoral Director		19a. Informant's Name/Relations	hip (Type, Print)								nber, City or To		
Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and In Important: If iten 27 is a injury or nather traumatic		O.C.M.E.							Stre		timore,		21223
Fear Tites	- 1	20a. Method of Disposition 1 Burial 2 Cremation	3 Remova	I		isposition (N or other plac		etery,		Date	20c. Location	- City or	Iown, State
Pages ent of	- 1	4 Donation 5 X Other S		state									
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		21 Signatur of Funeral Service	Licens@//	0	. 74	22. Name ar	nd Address	of Facility	oar	1 655 W	Ralti	more	Street
	1	1-X111/1	S. Wade,		31	Balti	more,	MD	2120		. Darer		Street
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ox 6 eath cer attendi	ᇙ	1 Yes 2 No 9 Un		egnant at time of o known	death 5	_ Other (S	oecify)				1000		
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ords, w require s been sig	Completed		···							24a. Was	an 24b.	Were au	topsy findings available
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of Vital ing Physician: After this certiful ineral director,	ၟႍ	1 ✓ Yes 2 No	Hospital: 1	Inpatient 2		atient 3					Residence 6		; Scene
ing Plang Pl		27. Manner of Death		ate of Injury onth, Day, Year)	28b. Tim	ne of Injury		y at Work?	- 1	28a. Describe	how injury occu	rrea	
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Division of an apptial or Attending Phonus after death. Inneral Director: After the funeral by filled in by the funeral or attention of the funeral or attention	Certification:	4 Homicide	ermined (Spec		known					unknow			
Hans Fun Fun		(all all all all all all all all all al	Physician: To the aminer:On the bas	best of my knowle	edge, death	occurred at	the time, da	te and plac	ce, and o	due to the caus	se(s) and manno and place, and	er as state due to th	ed. e cause(s)
To the within Tn the comple	edica		and manne		and/or IIIVE			_	an ou at	o amo, date			nth, Day, Year)
	Σ	29b. Signature and title of certifi	er) 00		1	29c. License						
		You U		oll.			O.C.I	vi.⊏.			Novembe	1 23, 20	/ I I
	İ	30. Name and address of person				0003	Al Deli:	aoro Ct-	not D	altimore #4	D 21222		
		Patricia Aronica-Polla		istant Medica			v. Baitin	iore Stre	eet, Ba	aitimore, M	D 2 1223		
Sta Registra	te ar	31. Date filed (Month DB, 20)	12 Se 132	. Registrar's Signa	gar	Kel							

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 1 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Wilbur Estep, Jr. December 2011 6:55 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) **Director** 218-56-7667 1 X M 2 | F 1949 Oct 31, Washington, DC 62 Usual Residence of Decedent 28a-f show 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits Director 1 Yes 2X No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8521 Grubb Road #102 20910 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married If Yes, Give Year or Dates 1970-1974 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Administrative Assistant Navy Contracts and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Wilbur Estep, Juanita Robertson Marjorie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ermit. Page 1 and 2 st epartment of Health a portant: If item 27 is Colleen Estep / Wife 8521 Grubb Rd. #102 Silver Spring, MD 20910 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🛣 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 1/6/2012 Final Journey Crematory Woodbine, Maryland 21. Signature of Funeral Service Licensee ^{22. Name and Address of Facility}
Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 21029 € MO1251 23a. Part 1. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Arteriosclerotic Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): burial-Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Day Year 5 Other (specify) Month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law performed 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\to \) Nursing Home 5 \(\to \) Residence 6 \(\to \) Other (Specify) 1 Yes 2 🔀 No ဂ္ 1 ☐ Inpatient 2 🔀 ER/Outpatient 3 ☐ DDA filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 X Natural 5 \square Pending 24 hours after death.

Funeral Director: A 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, within 2 To the F Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12.31,11

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature

toven

completed cause of death (Item 23a) (Type, Print)

MI

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MD

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1500 Forest Glen Rd. Silver Spring, MD 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1:00 PM M Month December 30. Y2011 Andrew W. Fleischmann Médical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Future Care Chesapeake Anne Arundel Arnold Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 86 10/10/1925 Maryland Director 213-20-5814 1 □ M 2 □ F show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director 1 Ves 2 No 28a-f Florida Lee Cape Coral 10e, Street and Number ms 23a or must be r ò 10f. Zip Code 10g. Citizen of What Country? Funeral USA 33909 1421 NE 3rd Terrace items death 12. Was Decedent Ever in U.S. Armed Forces?

1 1 Yes 2 No
If Yes, Give 1943 Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Medical Examiner Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after No 1943 - 1945 1 🗆 Yes 2 No Specify. SpecifWhite "natural" Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working al Hygiene. Elementary/Secondary (0-12) Machine Operator College (1-4 or 5+) Manufacturing the event, Be Department of Health and Mental Hy Important: If item 27 is marked of any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Leonard C. Fleischmann Myrtle E. Francis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald C. Fleischmann Son 7601 Water Oak Point Road Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jan 04 1 Burial 2 Cremation 3 Removal from State Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Cemetery 2012 ral Survice licens 21. Signatur 2. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road Pasadena Maryland 21122201 23a. Part 1, Enter the disease, or comp shock, or heart failure. List only on caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ End State Renal Disease Medical Due to (or as a consequence of) Examiner Lung Cancer Sequentially list conditions Examine if any, leading to immediate cause. Liner Underlying Cause (Disease or injury Due to (or as a consequence of): as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the المنابع Physician/Medical or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performe Yes 2 No 2 🗌 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🛄 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? Natural 5 Pending 2 🗌 No ☐ Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Division of Vital Records, P.O. Box 68760 Certificate: Director: After filled in by the 3 Suicide 4 Homicide after To the Hospital within 24 hours a 29a Certifier 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, Year) State Registrar

8601

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death $\overset{\text{Day}}{2}9$, $\overset{\text{Year}}{2}\overset{\text{Par}}{1}$ Physician/ 10:10 A M December Adeline Nancy Fisher Medical 4a, Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery Potomac Valley Nursing & Rehab Rockville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🕅 F Months Days Hours June 26, New York 91 115-16-2255 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b County 10c. City, Town or Location 10d Inside City Limits 10a, State Director 1X Yes 2 □ No Bethesda Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20814 U.S.A. 4619 West Virginia Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: "natural", Specify: 3 X Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 hand Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Samuel Vacanti Nancy Yanaka Department of Health and Important: If item 27 is m any injury or other traumanning. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4619 West Virginia Ave., Bethesda, MD 20814 19a. Informant's Name/Relationship (Type, Print) Robert Fisher (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Faith Memorial Park 1 X Burial 2 Cremation 3 Removal from State Huntsville, AL 01-06-2012 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee, 22. Name and Address of Facility Laughlin Funeral 2320 Bob Wallace Service Ave. SW unn Huntsville, AL 35805 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ lemell disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician hed for use as the burial Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 No Yes After this certificate has been signed by the funeral director, page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 XNC 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other 2 X No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After Injury work? 1 Yes 2 No 5 Pendina Accident Investigation completed filled in by the Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature 29c, License number 26 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

Men 31. Date filed (Month, Day, Year) 9043

Registrar's Signature

Box 68760 P.O. Records, Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_ FOI	tate of Marylar				/lental Hygi	ene	
		1 - State Registrar		Cer	tificate of L	Death		g. No. 2 1 1	1.2578
Physic	ian/	1. Decedent's Name (First, Middle, Last) Rosalba Mur	nia	Finf	rold.		2. Date of Death Month	Day Year	3. Time of Death 4:00 A M
Med Exam		4a. Facility Name (if not institution, give stree		FIIIT		Location of Death	December	4c. County of Death	-1
Exam	mer	14604 Little Wynn C				lywine			George's
Funera	al	5. Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Birth	pplace (State or Foreign
Directo	r	228-54-2614 1 M	² X 79	Yrs.	Months	770013	Aug. 28	1932	"" Italy
and show at	٥	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Loc	cation				10d. Inside City Limits
Maryla 18a-f	Director	MD Frederic	k:		Dicker	son			1 🗆 Yes 2 No
n the		10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	
th with ms 23 must	Funeral	1421 Linthicum Rd.		0 10 11	1	0842		United S	
Ind 21215-0036 filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ğ	1 Never Married 2 Married	Mas Decedent Ever in U. Armed Forces? I ☐ Yes 2 XNo f Yes, Give Year or Dates.	If	Yes, specify Cuba	spanic Origin? (Spen, Mexican, Puerto Specify:	ecity Yes of No- Rican, etc.)	14. Race - Ameri Black, White, Specify: Wh	
5-0 2 hour "natu	plet	15. Decedent's Educat (Specify only highest grade co			ent's Usual Occupa	ation during most of work	ina 1	6b. Kind of Business Ir	ndustry
121 thin 7 sne. than	Completed		College (1-4 or 5+)	life. DC	o NOT use retired) brarian			Research	
d 2	Be (17. Father's Name (First, Middle, Last)	2	1 22	Jean Lan	18. Mother's Nam	e (First, Middle, Ma		
/lan	유	Armando	Murgia		!	Desi		Gavina	
ore, Maryland 21. 1 and 2 should be filed with of Health and Mental Hygien fitem 27 is marked other tt		19a. Informant's Name/Relationship (Type, F Diane Reedy / Daugh	*		-	and Number or Rura		City or Town, State, Zip VA 2203	
altimore, mit. Page 1 and partment of Hea portant: If item y injury or other		20a. Method of Disposition 1 Burial 2 Cremation 3 Rem	oval from State	cemetery, crem	sition (Name of natory or other plac	e)		0c. Location - City or T	own, State
Itimo it. Page rtment o rtant: If njury or	,	4 Donation 5 Other (Specify)	Ch			ory 01/0			lle, MD
Baltimore permit. Page 1 a Department of H Important: If itel any injury or oft		21. Signature of Funeral Service Litensee	Moess						910
		23a. Part 1. Enter the disease, or complicati shock, or heart failure. List only one ca Immediate Cause (Final	ons that caused the deat use on each line.	th. Do not ente	r the mode of dyin	g, such as cardiac o	or respiratory arrest	t,	Approximate Interval Between Onset and Death
Pnysician Medica		disease or condition resulting in death)	Due to (or as a conseq	Star	Je De	Men	tia		years_
Examine	_		Due to (or as a conseq	derice or).	7				'
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executed an and rial-transi	xam	Cause (Disease or iinjury that initiated events c	Durate (assessment						
760 ate be executed physician and the burial-transit	dicalE	resulting in death) Last	Due to (or as a conseq	uence or):					
760 cate b physic	edic	d							
Ital Records, P.O. Box 68/60 sician: The law requires that the death certificate be certificate has been signed by the attending physici rector, page 2 should be detached for use as the bu	Physician/Me	in the past 12 months?	f yes, outcome of pregnal Live Birth 2 Feta Pregnant at time of Common Unknown	al death 3 🗌	Ectopic pregnanc Other (specify)	y		23d. Date of deliv Month	very Day Year
ords, P.O. requires that the been signed by the should be detach	by Ph	Part II. Other significant conditions contrib	uting to death but not res	sulting in the u	nderlying cause giv	ren in Part I.	23e. Did toba	acco use contribute to t	the cause of death?
dS, quires en sig ould b	ted						1 🗆 Yes	2 No 3 Pro	obably 4 🗌 Unknown
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f Vital Physician: this certific al director,	Be	25. Was case referred to medical examiner?	tal			ace of Death (Chec			ASSISTED
↑ Physthis this aldi	<u>اد</u>	1 L Yes 2 No	1 Inpatient 2	ER/Outpatien 28b. Time of	t 3 DOA Othe	4 ☐ Nursing Ho	ome 5 Residen 28d. Describe how	ce 6 Other (Specif	W CLUING
on on or or or or or or or or or or or or or	cate	1 ★ Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year)	injury	work	? Yes 2 No	200. Describe now	rinjury occurred	
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Certificate:	3 Suicide 6 Could not be	8e. Place of Injury - At he building, etc. (Specify		et, factory, office		28f. Location (Stre City or Town,	et and Number or Rura State)	d Route Number,
To the Hospital within 24 hours a To the Funeral I completed filled	Medical	29a. Certifier 1 Certifying Physician (Check 2 Medical Examiner: Only one) 3 Certifying Nurse Pra	: To the best of my know On the basis of examination actioner: To the best of m	n and/or invest	igation, in my opinio	on, death occurred a	t the time, date and	place, and due to the ca	ause(s) and manner stated.
To the vithing complete the com		29b. Signature and title of certifier		. 1 🐧	29c. License			d. Date signed (Month,	
		lan un	- CR	NP	IK/S	14/8	1	01-03	- 2012
151		30. Name and address of person who compl	eted cause of death (Item	1 23a) (Type, P	1000 Suka	brech.	tRd MD2	1784	
St Regist	ate trar	31. Date filed (Month, Day, Year) JAN 0 6 2012	32. Registrar's Signa	ture					
		JANUO ZUIZ	de a.	to da Kas					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 ea December 1:24 PM M Medical Ellwood L. Fletcher 4a, Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 331 E. University Pkwy Baltimore cial Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) 219-26-8595 72 1 X M 2 D F Director April 8, 1939 Maryland 28a-f show 10a, State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 X Yes 2 No MD Baltimore 5 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral items 23a USA 21218 331 E. University Pkwy "natural", or item 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry unk (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Ellwood LeRae Fletcher Sr. Eleanor LeCompte 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Palombo - sister 2810 36th St; Baltimore, MD 21218 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board Signature of Eureral Service Licenses Rona La S. Wade Hector 655 W. Baltimore St; Baltimore, MD 21201 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ oronary artery Oyear Medical Due to (or as a consequence of): **Examiner** cardiac months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ type 11 charles Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Chronic renal insufficiency 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 TDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No s after death.

I Director: Aff 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Falls Luther ville 53 1093

State Registrar 07

6 2012

Box 68760

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Division of Vital

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	Examin	er	4a. Facility Name (if not ins			ber)			rows					ALTI	of Death	E	
	Funeral Director		5. Social Security Number 212 32 894 Usual Residence of Dece	8	Sex 1 □ M 2 X F	7. Age (<i>In yrs.</i> 78	last birthday) Yrs.	If Und Months	er 1 Year Days	If Under 2 Hours	Min.	8. Date of Bi	rth a <i>y, Year)</i> 0 / 1 9	33	Counti	ace (State or Ford y) UCKY	eign
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-	with the M 23a or 28 ist be not	Funeral Director	10e. Street and Number 7406 MEAD	OW B	RANCH	CT API	ГВ		ip Code 2123	7				itizen of W	/hat Count	y?	
920	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Health and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show either traumatic event, the Medical Examiner must be notified at	β	11. Marital Status 1 Never Married 2 3 X Widowed 4 Di		Armed Fo	2 & No				ispanic Orig n, Mexican, Specify:	in? (Spe Puerto	ecify Yes or No- Rican, etc.)	-		- America k, White, e		
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Maryland	d 2 should realth and Me		19a. Informant's Name/ReRAY FLEMIN	ationship (-1	_		and Number	or Rura	l Route Numb	er, City o			nde) ARE 1996	58
imo	rage nent c ant: If ury or		20a. Method of Disposition 1 ☐ Burial 2 XCrer 4 ☐ Donation 5 ☐ 0	nation 3 [☐ Removal from	State	Place of Dispo cemetery, crer CTRO CR	sition (Na natory or	ame of other plac	e)	[Date 04/2012	20c. L	ocation -	City or Tov	/n, State	
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	hysician Medical		23a. Part 1. Each the dise shock, of heart failure Immediate Cause (Final disease or condition resulting in death)	ase, or con e. List only	a. LUNG	aused the deach line. CANCE or as a consec	th. Do not ente									Approximate Interval Between Onset and Death	
1000	ician and purial-transit	cal Examiner	Sequentially list conditions if any, leading to immediat cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last	Se	c	or as a consec						* * * * * * * * * * * * * * * * * * * *					
Division of Vital Records, P.O. Box 68760	r the attending physician and ched for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 □ Yes 2 🛣 No 9 □ Unknown	nt ?		Birth 2 🗌 Fet nant at time of	tal death 3	Ectopic Other		:y				23d. Date Mor	e of deliver	y Day Year	
ls, P.O.	been signed by the s should be detached	þ	Part II. Other significant c	onditions	contributing to d	eath but not re	sulting in the u	ınderlying	g cause giv	ven in Part I.						cause of death?	
Records,	nis certificate has bee al director, page 2 shor	Completed										24a. Was auto perf 1 🗆 Yes	opsy ormed?	p		sy findings availa pletion of cause	
Vital	certific irector,	Be	25, Was case referred to m examiner? 1 ☐ Yes 2 👿 No	edical	Hospital;		1		Othe	ace of Deather:						HOGOTON	
n of V	th. After this funeral di	cate: To	27. Manner of Death 1 X Natural 5	Pending Investigation	28a. Date (Mont	Inpatient 2 of injury th, Day, Year)	28b. Time of injury		28c. Injury work	/ at	1	me 5 Resi 28d. Describe				HOSPICE	
Division	within 24 hours after death. To the Funeral Director: A completely filled in by the f	Certificate:	3 Suicide 6	Could not lidetermined	be 28e. Place	of Injury - At h	ome, farm, str				-	28f. Location (City or To			r or Rural F	Route Number,	
- :000		Medical	(Check 2 Me	dical Exan	ysician: To the b niner: On the bas rse Practitioner	is of examination	on and/or inves	tigation, i	my opinio	n, death occ	curred at	the time, date	and place	e, and due	to the caus	e(s) and manner :	stated.
T C	within 2 To the comple		29b. Signature and title of	egrtifie AIA	20 CAN	P		29	RIY	number GJG	2		29d. Da	ate signed	(Month, D	ay, Year)	
	√		30. Name and address of JACKIE JON		completed caus	00 DUL	ANEY VA	LLEY	RD.	TIMO	ONIU	M, MD	2109	3			
	Stat Registra	te ar	31. Date filed (Month Ca)		acours, 32. R	egistra s Signa	tarkel)									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 12 Month Physician/ 23 2011 7:30A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Baltimore 3437 Woodstock Ave. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** West Indies 1 - M 2 - F Months Hours 0172071929 82 Director 085-10-0351 Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director , or items 23a or 28a-f s aminer must be notified ¥☐ Yes 2 ☐ No Baltimore MD N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21213 U.S.A. 3437 Woodstock Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify 3 ₩ Widowed 4 □ Divorced Black "natural" Completed Year or Dates the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than nentary/Seconday (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic event than the Mental Count that the Mental Count the College (1-4 or 5+) 12th Grade Rising Sun Store Owner Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Louisa Samuel Richard H. Samuel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3437 Woodstock Ave., Baltimore, MD 21213 Vernareen Johnson(daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗌 Burial 2🔀 Cremation 3 🗌 Removal from State On-siteCrematory 01/04/12 Baltimore, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, Р<u>А</u> мD21217 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a cons Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of Exami sician and burial-transit requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant Pregnant at time of death 5 Other (specify) been signed by the should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law r within 24 hours after death.

To the Funeral Director: After this certificate has b completed filled in hv the funeral state. autopsy performe 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ₽ 🖸 No ဂ္ 1 🗌 Yes 🍃 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Natural 28d. Describe how injury occurred Certificate: 5 Pending 1 Yes Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Date signed (Month, Day, Year) 29b. Signature and title of certi Ĵ and address of person who completed cause of

Registrar
DHMH 17 Rev 7/2009

State

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 20 | |

,	For State	State of Ma	aryland		ment of H icate of D			4	2011	4258
	Registrar 1. Decedent's Name (First, Middle, Las	st)		Certin	cate of D	catri	2. Date of Dea			3. Time of Deat
Physician/ Medical	Sylvi	а В.	G1a	zer			Decembe		2011	1:20 A
Examiner	4a. Facility Name (if not institution, give				o. City, Town, or Bethesda	Location of Death	٦		County of Deat	
Funeral	Suburban Hospita1 5. Social Security Number 6. Se		(In yrs. last	birthday) If	Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	th	9. Birl	thplace (State or For
ector	043-16-4346 Usual Residence of Decedent	□ M 2 🗶 F 9 O)	Yrs.	Official Days	Tiodio Timi	June 2,			nnecticut
٥	10a. State 10b. County			Town or Location						10d. Inside City Lin
Director	Maryland Montgom	nery	Chev	y Chas	e					1 🗌 Yes 2 💆
	10e. Street and Number				10f. Zip Code				en of What Co	ountry?
Funeral	8100 Connecticut	Ave. Apt.		13. Was	20815 Decedent of Hi	spanic Origin? (S	pecify Yes or No-	U.S	A. Race - Ame	erican Indian,
ed by F	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.			s, specify Cuba	spanic Origin? (S n, Mexican, Puert Specify:	o Rican, etc.)		Black, White specify: Wh	e, etc. nite
plete	15. Decedent's E (Specify only highest gra			(Give kind	's Usual Occupa of work done of	ation during most of wo	rking	16b. Kin	d of Business	/Industry
Completed	Elementary/Secondary (0-12)	College (1-4 or 5	i+)	Teache	OT use retired)			Edu	cation	
Be (17. Father's Name (First, Middle, Last)					18. Mother's Na	me (First, Middle,	Maiden S	urname)	
욘	Herman Bergins					Mary St				
	19a. Informant's Name/Relationship (T	**				and Number or Ru				ip Code)
any injury or other traumatic event, the Medical Examiner must be nouried autonce. To Be Completed by Funeral Director	Patti Chapell/Dau	ghter	20h Pla	ce of Disposition		ring Dr.	Date		cation - City or	r Town, State
	1 XBurial 2 Cremation 3 4 Donation 5 D Other (Specia		000	notoni oromati	and or other place	ParkDec.		l	_	
once.	21. Signature of Funeral Service Licens	Gary R.	. Downe	1	ame and Addres	ss of Facility Mo	ney & K	ing F	uneral	Home, In
	23a. Part 1. Enter the disease, or com	CCO 508	the death.	Do not enter th	ne mode of dyin	Maple A	c or respiratory a	rrest,	Va. Z	Approximate Interval Betwee
an/	shock, or heart failure. List only of Immediate Cause (Final disease or condition	one cause on each line		10						Onset and Dear
ical iner	resulting in death)	Due to (or as a								
	Sequentially list conditions,	b. Due to for each	e motien i tra	nes all:						
edical Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	- San ic (si san								
edical Examiner	that initiated events resulting in death) Last	Due to (or as	a conseque	nce of):			_			
dica		d								
Me	IF FEMALE:	23c. If yes, outcome	of pregnance	CV					23d. Date of de	eliven/
Completed by Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live Birth 4 ☐ Pregnant a	2 Fetal	death 3 🗌 E	ctopic pregnand other (specify)	cy	<u></u>		Month	Day Yea
hysi	1 Yes 2 No 9 Unknown	9 Unknown	_							
by P	Part II. Other significant conditions of	contributing to death b	out not resul	Iting in the und	erlying cause gi	ven in Part I.				to the cause of deat
ted							VI.			
mple								s an opsy formed?	prior to death?	
ပိ	25. Was case referred to medical	1			26 P	lace of Death (Ch		2 X No	1	es 2 No
To Be	examiner? 1 Yes 2 No	Hospital:	ient 2 🗆 E	R/Outpatient	Oth	or	Home 5 Res	idence 6	Other (Spe	ecify)
je j	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of inju	iry 2	28b. Time of injury	28c Injur	v at	28d. Describe			
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ificat	2 Accident Investigation			ne, farm, street	, factory, office			(Street and wn, State)		lural Route Number
Certifical	2 Accident Investigation 3 Suicide 6 Could not lead to the determined determined		C. (Specify)							
ely filled in by the funera dical Certificate:	3 Suicide 6 Could not learning determined	building, etc.	f my knowle	and/or investiga	ation, in my opini	on, death occurred	d at the time, date	and place,	, and due to the	e cause(s) and mann
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DHMH 17 Rev 06-2011

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			For	State	of Maryland		rtment of H		and Me	ental Hygi	ene 2 (42583
_		1	State Registrar			Cert	ificate of D	eath)			eg. No. C	7 1 1	
	Physicia	n/	Decedent's Name (First, Midd		TDGGS					Date of Death Month	Dav	Year	3. Time of Death
	Medic	al			IBSON					December	1	2011	0552 M
	Examin	er	4a. Facility Name (if not institutio	_	mber)		4b. City, Town, or				4c. County	of Death	
******	*		Holy Cross Hos 5. Social Security Number	Spital 6. Sex	7. Age (In yrs. Ia	et hirthdayl	Silver If Under 1 Year	Sprin		8. Date of Birth	Mont		ace (State or Foreign
	Funeral Director		579-74-6250	1 M 2 X F			Months Days	Hours	Min.	(Month, Day,		Counti	y)
	The same of		Usual Residence of Decedent	1 2 10 2 23	56	Yrs.			l P	Mar 29,	1955	L	DC
	shov d at	tor	10a. State 10b. Count	y	10c. City	, Town or Loc	ation					10	d. Inside City Limits
	Mary 28a-f otifie	irec	MD Monts	gomery	St	llver S							1 Yes 2X No
	a or be no		10e. Street and Number				10f. Zip Code			1	0g. Citizen of	What Count	ry?
	nust	Funeral Director	1945 Rosemary				2091				USA		
	death item ner n		11. Marital Status	Armed Fo	edent Ever in U.S orce <u>s?</u>	i. 13. W	as Decedent of Hi Yes, specify Cuba	ispanic Orig n, Mexican	gin? (Spec ı, Puerto R	ify Yes or No- ican, etc.)		ce - America ck, White, e	
36	after I", or xami	d by	1 Never Married 2 Ma 3 Widowed 4 Divorce	. If Yes, Gir		1	☐ Yes 2 ﷺ No	Specify:			Specify.	Bla	o.k
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פַ	illed \	Be	17. Father's Name (First, Middle,	Last)				18. Mothe	er's Name	(First, Middle, M	laiden Surnam	ie)	
/lar	d be Menta	입	Samuel Dozier	, Jr				Mary	y Ali	ce Mars	hall		
an.	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	33	19a. Informant's Name/Relation	ship (Type, Print)			g Address (Street a				City or Town,	State, Zip C	ode) 20910
2	and 2 s Health tem 27		Antoine Gibson	n - Son			Rosemary	Hi11			Silver		
ore			20a. Method of Disposition 1 Burial 2 Crematio	n 3 🗆 Removal fror		lace of Disposemetery, crem	sition (Name of eatory or other plac				20c. Location		wn, State
Ξ	tmen tant: jury		4 Donation 5 Other		Her		Cemetery		1-6-2		Waldor		
Baltimore, Maryland 21215-0036	permit. Page Department of Important; If any injury or once.		21. Signature of Funeral Service	Licensee	1-110		Nama 11dd M						ıd
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00	cate be executed physician and s the burial-transit	Physician/Medical		d									
Box 68760	tificat ng ph e as th	Me	IF FEMALE:										
9 ×	eath certifica attending p	ian/	23b. Was decedent pregnant in the past 12 months?	1 🔲 Live		al death 3	Ectopic pregnand	СУ				ate of delive onth	ry Day Year
Bo	deat the at hed fo	ysic	in the past 12 movins? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 □ Pre 9 □ Unl	gnant at time of o known	death 5∟	Other (specify) _						/
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S, F	signe d be	d by								1 🗆 Ye	es 2 🗆 No	3 🗌 Prob	pably 4 Unknown
ğ	requi	ete								24a. Was a	n 24b		osy findings available
Records,	The law ate has page 2:	Completed								autops perform	med?	death?	npletion of cause of
<u> </u>	ician: The certificate rector, pag		25. Was case referred to edic	al			26. P	lace of Dea	ath (Check	1 Yes	2 No	1 Yes	2 L NO
/ita	/sicia s cert direct	To Be	examiner? 1 Yes 2 No	Hospital:	Inpatient 2	ER/Outpatier	t 3 🗆 DOA Oth	er: 4 \square Nu	ursina Hor	ne 5 🗌 Reside	ence 6 🗆 Ot	her (Specify	
of	Jing Physician: After this certific funeral director,		27. Mann of Death	28a. Date	e of injury onth, Day, Year)	28b. Time of injury	28c. Injur	y at		8d. Describe ho			
no	ath. r: Aft	ical		stigation	min, Day, Toar)	,,	M 1 🗆	Yes 2] No				
Division of Vital	r Atte	Certificate:	3 Suicide 6 Cou 4 Homicide dete	rmined 28e. Plac	ce of Injury - At ho		et, factory, office		2	28f. Location (St City or Town		ber or Rural	Route Number,
Ö	ital or al Di												
	Hospital or Attending 24 hours after death. Funeral Director: After stely filled in by the fune	Medical	Check 2 Medica	ng Physician: To the I Examiner: On the ba	asis of examinatio	n and/or invest	igation, in my opini	on, death or	occurred at	the time, date an	d place, and d	ue to the cai	use(s) and manner stated.
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Ž	only one) 3 L Certifyi 29b. Signature and title of certifyi	ng Nurse Practition	er: 10 the best of r	ny knowledge,	death occurred at 29c. Licens		ate and pia		e cause(s) and 9d. Date sign		
_	F ≥ F ŏ		1 tend	-11	- m			4348			12-27		
	•		30. Name and address of person	on who completed ca	use of death (Iten	1 23a) (Type. F		.540					
ì	V		Steven Gruffe		1500 Fo	rest G	lenn Dr.	Sil	ver S	Spring,	MD 209	10	
	Sta	te	0.1 Data filed (Manth Day Voor	1 00	legistrar's Signa	tur	. 1.1						
	Registr	ar	O MAL.	6 2012	mun ,	D. 496							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42584 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12 Year 02:15 M 3 DREW Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 517 Ridgely Avenue Annapolis Anne Arundel Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 300-50-9835 **Director** 1 XM 2 🗆 F 60 September 17,1951 Ohio Usual Residence of Deced 28a-f show ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21401 United States 517 Ridgely Avenue 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 2 D No 1969-10 1 Never Married 2 X Married þ X Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: White 3 Widowed 4 Divorced Completed 1972 Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Concrete Waterproofing than Elementary/Secondary (0-12) College (1-4 or 5+) the and Restoration 12 Caulker Be 17. Father's Name (First, Middle, Last) th and Mental h 18. Mother's Name (First, Middle, Maiden Surname) မ Andrew John Hurajt, Sr. Helen Louise Fedor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s if Health item 27 517 Ridgely Avenue, Annapolis, Maryland 21401 Pamela Ruth Hurajt/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State January 5, 20<u>12</u> Page 1 1 Burial 2 X Cremation 3 Removal from State West Arunde1 4 ☐ Donation 5 ☐ Other (Specify) Crematory Odenton, Maryland Signature of Funeral Service Licenses Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113 Will Expores **7** M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between
Onset and Death
MUNTES Immediate Cause (Final Physician/ CANCER LUNG disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last physician Physician/Medical death certificate be 68760 as yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery Box (in the past 12 months? Month Dav Year 1 Yes 2 No ed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be de 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 2 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Hospital: Other: 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending ➤ Natural 5 Pending 1 Yes 2 No Accident To the Hospital or Attency within 24 hours after death To the Funeral Director: / Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 445 Defense Huy ANNAPalis Ms 21401 State

Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 45 GIRI Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death SPRING SIWER CROSS HOSPITA MONTG - C Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Director 1 🗆 M 2 🔽 F 25, 2011 28a-f show 10b. County 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 ¥Yes 2 ☐ No DC WASHINGTON WASHINGTON 10e. Street and Numbe 10f. Zip Code 10g Citizen of What Country? Completed by Funeral 410 USIA NW Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give 3 Widowed 4 Divorced A ACK Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) INFANT INFANT A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) d Mental | ၉ JEROME DIONNB JONES TONES N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i CROSS HOSPITAI RD HOLY COLEN SILVER SPRING MI 1500 PORRST 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

□ Departure 5 ★ Other (Specify) in state 4 Donation 5 Dother (Specify) Signat f Funeral S State Anaton Board 655 W. Baltimore Street Director MD 21201 Baltimore. 23a. Part \ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PREMISTURI Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): CHORIOAMNIONITIS use as the burial-trans and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ☐ Live Birth 2 ☐ Fetal dea ☐ Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☐ No Day signed by the a Hospital or Attending Physician: The law requires that the 24 hours after death.
Funeral Director. After this certificate has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death?
1 Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 ☐ Yes 2 MNo Hospital မ 1 M Inpatient 2 - ER/Outpatient 3 - DOA 27. Manuar of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury Natural work?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical ertifyin hysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical E miner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F iv one) 3 🔲 29b Signature and title of 29d. Date signed (Month, Day, Year) D 31265 12-25-2011 d cause of death (Item 23a) (Type, Print) 30. Name and address of person who comp

State Registrar 4000 HITCHELLVILLE RD BOWIE, MD 20716

RR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 1

		1	For State Registrar	State of Maryland	/ Depa	artmen tificate	t of H e <i>of D</i>	ealth ar <i>eath</i>	nd Menta		ene 2 ()	42586
		_	Decedent's Name (First, Middle, Last)							te of Death	n Day	Year	3. Time of Death
	Physicia Medic	al	Adrienne Jackson							2	26	2011	1605 M
	Examin	er	4a. Facility Name (if not institution, give stre			4b. City,		Location of [1timo:			4c. County	of Death	
inesis	Funeral		Union Memorial Ho 5. Social Security Number 6. Sex	7. Age (In yrs. las	t birthday)	If Under	1 Year	If Under 24	Hrs. 8. Dat	te of Birth			place (State or Foreign
	Director			M 2 🗓 F 45	Yrs.	Months	Days	Hours		onth, Day, ' e 14.	1966	Coun	yland
	d it		Usual Residence of Decedent 10a, State 10b. County		Town or Lo	cation						1	0d. Inside City Limits
	arylan a-f sh ified a	Director	MD			imore							1X ☐ Yes 2 ☐ No
	or 28 or 28 e not		10e, Street and Number		Dare	10f. Zip				10	0g. Citizen of	What Cour	itry?
	is 23a	Funeral	2728 Hugo Street					21218				USA	
	death ritem iner n	/ Fui	11. Marital Status 1 X Never Married 2 Married	2. Was Decedent Ever in U.S. Armed Forces?	13. \ I	Vas Deced f Yes, spec	lent of His afy Cubar	spanic Origin n, Mexican, F	n? (Specify Ye: Puerto Rican,	s or No- etc.)		ce - Americ ck, White,	
980	s after al", o Exam	d by	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2X No If Yes, Give Year or Dates.		☐ Yes	2 🌠 No	Specify:			Specify	/: b1a	ick
2-0	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho Aedical Examiner must be notified at	olete	15. Decedent's Educ (Specify only highest grade		16a. Deced	dent's Usua kind of wo	al Occupa rk done d	ation uring most o	of working		16b. Kind of E	Business/In	dustry
121	within 72 giene. ier than ' i, the Me	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. D	o NOT use erica	retired)				postal	syst	em
d 2	filed within all Hygiene.	l as l	17. Father's Name (First, Middle, Last)					18. Mother's	's Name (First,	Middle, M	aiden Surnan	ne)	
lan	l be fil fental rked tic ev	욘	Issac Jackson						Glori	a you	ıng		
Mary	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 20 or 20 or 20 other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type Shirley Drayton/a		19b. Mailir 1704	E · 3	(Street a 2nd	nd Number of Street	or Rural Route Balti	more,	City or Town, MD 2	State Zip (21218)	Jode)
Baltimore, Maryland 21215-0036	Page 1 and healt of Healt int. If item 2 iny or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☑ Other (Specify)		ace of Dispo metery, crer	sition (Nar natory or c	ne of other place	e)	Date		20c. Location	- City or To	own, State
Balti	permit. Page 1 a Department of I Important: If ite any injury or of		21. Signature neral rivice lice	MD 2	ard 65 1201			ore S	Street				
	Medical Medical Examiner	ıer	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deatt									Approximate Interval Between Onset and Death — 30 Minwij	
90	ath certificate be executed attending physician and for use as the burial-transit	dical Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):								
. Box 6876	for the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. In the Funeral Director, After this certificate has been signed by the attending physician the Funeral Director, After this certificate has been signed by the attending physician properties of the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ic. If yes, outcome of pregnar 1 Live Birth 2 Fetal 4 Pregnant at time of do	death 3	☐ Ectopic ☐ Other (s	pregnanc	су				ate of deliv	very Day Year
ls, P.O.	requires that the des been signed by the s should be detached	2	Part II. Other significant conditions con	tributing to death but not resu	ilting in the	underlying	cause giv	ven in Part I.	2				the cause of death?
Division of Vital Records,	The law req	Completed								24a. Was a autops perfori I Yes	sy me <u>d</u> ?	were auto prior to co death? 1 \(\subseteq \text{Yes}	opsy findings available ompletion of cause of
ta	sician: The certificate irector, pag	Be	25. Was case referred to medical examiner?	ospital:			LOth	or:	(Check only				
fVi	Physi this o ral din	2	1 L Yes 2 No	1 Inpatient 2 L	ER/Outpatie 28b. Time o		OA C	4 ∟ Nur	rsing Home 5		ence 6 LL Of ow injury occu		γ)
0 U	iding F th. After s funer	cate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	М	work						
ivisio	Hospital or Attendii 24 hours after death. Funeral Director. A etely filled in by the fu	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hos building, etc. (Specify)		reet, factor	y, office		28f. L	ocation (St lity or Town	treet and Num n, State)	ber or Rura	al Route Number,
_	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	(Charle 2 Modical Evamine	cian: To the best of my knowler: On the basis of examination Practitioner: To the best of m	and/or inve	stigation in	my opini	on, death occ	curred at the tar	me, date and and due to the	nd place, and d ne cause(s) and	manner as	stated.
ø	To the within com		29b. Signature and title of certifier	MD			AT.	e number 243	8946	<u> </u>	29d. Date sign	8 - 1	2011
			30. Name and address of person who co	mpleted cause of death (Item 20) 32. Registrar's Signat	23a) (Type, East	Print)	res;	ty Pa	r Kwny	Ba	Itimor	Y, M	D 21218
	Sta Registi		31. Date filed (Month, Day, Year) JAN 0 6 2012	32. Registrar's Signat	par	Kel							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ M Johnson Robert pec 2011 : 31 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner University of Maryland Medical Center Baltimore 8. Date of Birth (Month, Day, Year 6/14/1951 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last b. **Funeral** Months Min. 1**X** M 2 □ F Hours 59 213-60-7629 **Director** Usual Residence of Decede show 10d. Inside City Limits

1 Yes 2 No 10a. State 10c. City, Town or Location notified at Director **Baltimore** 28a-f **Baltimore City** MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò must be Funeral U.S.A. 23a 21223 2325 South Hollins Street items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner Armed Forces?

1 X Yes 2 No Black, White, etc þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black If Yes Give Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Disabled Disabled 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Sarah E. Cann Carlton Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2325 South Hollins Street Baltimore, MD 21223 July Johnson Judy Johnson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Owings Mills, Md. Jan 11, 2012 **Garrison Forest Veterans** 4 Donation 5 Other (Specify) 22. Name and Address of Facility

Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cowonawy awtery disease or condition Medical resulting in death) Due to (or as a consequence of Examiner resection and colos formy Colon ischemia Gaquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) weduced rentride function attending physician and I for use as the burial-transit congestive heart that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical It ypertensian Hospital or Attending Physician: The law requires that the death certificate be Diubettes Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4 Pregnant a 5 Other (specify) Pregnant at time of death been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , page 2 has autopsy performed' Yes 2 No 1 Yes 2 No certificate Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: ဥ 1 X Yes 2 🗆 No 1
Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Medical Certificate: 28b. Time of 28d. Describe how injury occurred 5 Pending iniury 1 Natural 24 hours after death. Funeral Director: A Accident Investigation filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 within 2 To the F the only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1306151386 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Ellicott Crity, MD 21043 Hashim3253 Normandy woods assan 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JAN 0_6 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) Physician/ December 23,2011 ear 5:30P Pauline Lee Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Balto. Roseda1e 195 Attenborough Dr. If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 189-36-9759 Usual Residence of Decedent **Director** 94 1 □ M 2 🗓 F China 9-17-1917 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location notified at Director Rosedale Md. Balto. 1 ☐ Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a or Funeral USA 21237 195 Attenborough Dr. Apt.103 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: I fiem 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 XNo Black, White, etc. 1 Never Married 2 Married ð Baltimore, Maryland 21215-0036 Chinese 1 Yes 2 XNo Specify: Yes Give 3 X Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Home Homemaker 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Unknown Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5006 Dorothy Field Road Perry Hall, Md. 21128 19a. Informant's Name/Relationship (Type, Print) 5006 Dorothy Field Road DTR. Jean Tang 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place) Silver Spring. Md. 1-4-2012 Gate of Heaven 22. Name and Address of Facility Schimunek Funeral Home Inc. 9705 Belair Road Nottingham, Md. 21236 21. Signature of Funeral Service Licensee 8666 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Unsat and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Exam the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths?

1 Yes 2 No
9 Unknown for Day Month Year 5 Other (specify) Pregnant at time of death 9 Unknown detached Division of Vital Records, P.O. signed by tall be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should Were autopsy findings available prior to completion of cause of autopsy perform 1 ☐ Yes 2 No 1 Yes 2 No director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this filled in by the funeral 27. Manner of Death 28c. Injury at work? _1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending injury 24 hours after death. Funeral Director: A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completely i Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and **Se** of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S.S SACHDEV MD , 126 A, E H E High ST, ElhIn MD 21921. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2011 42589
State of Marvland / Department of Hoolth and Marvlal University

Preston Lemon State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Time of Death Month Day December 8, 2011 Medical Examiner 1406 hrs Lemon Preston 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 628 N. Eutaw Street Apt. 403 Baltimore 5. Social Security Number 111k 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or unk **Funeral** Foreign Country) Months Davs Hours Director Sept 22, 1950 61 2 F Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits jes I am & surces...
of Health and Mental Hygiene.
: If item 27 is marked other than "natural", or items 23a or 28a-f show
wher traumatic event, the Medical Examiner must be notified at once. 1 X Yes 2 No Baltimore should be filed within 72 hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21202 USA #403 628 N. Eutaw Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, unk If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces White, etc. Married 1 Never Married 2 unk 1 Yes 2 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: black 2 16a. Decedent's Usual Dccupation (Give kind of work done unk 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ltimore, MD 21215-0036 unk 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) unk unk Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 900 W. Baltimore Street Baltimore, MD 21201 O.C.M.E. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State Donation 5 X Other Specify 2in 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Raltimore, MD 21201 21. Signature of Funeral Service Lice 23a. Palt I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and Listenly one cause on each line /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease **±**xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown acate has been signed by the page 2 should be detached f. Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. ò 1 Yes 2 No 3 Probably 4 V Unknown Diabetes Mellitus Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has performed? death? ✓ Yes 2 No 1 Yes funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) the Hospital or Attending Physician: æ Hospital: 1 Inpatient 2 Dther4 Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 DOA 1 Yes 28a. Date of Injury (Month, Day,Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natural 1 Yes 2 No death. Pending the Director: 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City hours after 3 Could not be Suicide or Town, State) within 24 hours at To the Funeral I determined (Specify) 4 Homicide completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E December 9, 2011 30. Name and address of person who completed cause of death (Item 23a) Patricia Arpnica-Pollak MD. Assistant Medical Examiner 900 W. Baltimpre Street, Baltimpre, MD 21223 32. Registrar's Signature State Pay 6 Registrar

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Dec. 201°1 Merriam 3:36 P Barbara Ruth Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Months 78 **Director** 1 □ M 2 🛛 F 217-30-0857 Jan. 9, 1933 Maryland Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 11/18/11 Director Cape Coral 1 XYes 2 No FLLee 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 33904 4940 Vincennes St. #106 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married ☐ Yes 2X No þ Saltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give White Completed 3 - Widowed 4X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Secondary (0-12) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Tipton Ruth Bennett Harrison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15309 Gable Ridge Ct., Rockville, MD James K. Merriam / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2XXCremation 3 Removal from State Chesapeake Crematory 01/05/2012 Beltsville, MD 4 Donation 5 Other (Specify) 21. Sign are of unwart, vice Licensee Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Intravascular Coaquiation Physician/ a Disseminated disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): burial-transit po te 1510r Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Panreaditis Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the at d be detached for Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of death? autopsy has performed? 1 🗆 Yes 2 🗆 No To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 Yes 2 No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred s af er death iniury 1 Natural 5 \square Pending 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 2,2012 64502 January 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville, MD medical Car. Dr. 20850 9901 MD arpender (Month, Day, Year) JAN 0 6 2012 /32. Registrar's Signature State Registrar

1536

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 42591 Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month John George Murine Jr. 2011 9:31 AM December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltim<u>ore</u> Stella Maris Hospice Timonium 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min 283-36-2730 Director 1 🛛 M 2 🗆 F 73 Yrs. Dec 14, 1938 Ohio Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Harford Bel Air Marvland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 1405 Vermont Road 21014 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, item 27 is marked other than "natural", or iten other traumatic event, the Medical Examiner Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🄀 No If Yes, Give 3altimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 land Mental Hygiene.
7 is marked other than "r College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Software Engineer Defense Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ DECÉMBER 30, John George Murine Agnes Majzun 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at Important: If item 27 is any injury or are Sara R. Murine, Wife 14226 Kendra Way Poway, CA 92064 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, 01/04/12 Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Licer 22. Name and Address of Facility
Cremation Society Of Maryland, Inc.
299 Frederick Road Baltimore, Maryland 21228 Thomas Gregor homai that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or each line. 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Interval Between Immediate Cause (Final Onset and Death Physician/ PULMONARY FIBROSIS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence ci): Exami Due to (or as a consequence of): resulting in death) Last attending physician for use as the buris Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Division of Vital Records, P.O. Box 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year been signed by the a should be detached 1 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 performe certificate 2 🗆 No 1 Yes Yes 2 💢 No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No မ 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death. To the Funeral Director: After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred X Natural 5 Pending Investigation 6 Could not be Accident 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗶 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) 201 on who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. **CRNP** JACKIE JONES, TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State

Registrar

31. Date filed (Month

JAN 0 6 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar 42592 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month langium AM Cuald DECAMBEY 1105 7:31 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Harber 8. Date of Birth Jan 28, Year) Jan 28, 1953 Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F Hours Director 213-66-2230 Washington DC 58 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County items 23a or 28a-f sho ner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 3618 5th Street 21225 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ō 1 Never Married 2 ☐ Married Completed by 1 X Yes If Yes, Give Baltimore, Maryland 21215-0036 2 🗌 No 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 🗌 Widowed 4 🗀 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) disabled none Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John D. Mangrum Frances E. Stoutseynberger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Vogel/friend 3618 5th Street Baltimore, MD 21225 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🔀 Other (Specify) Signature of Funeral Struct State Anatomy Board 655 W. Baltimore Street MD equer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1 shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth Z L 1 e.c. ____ Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 \(\subseteq \text{Yes} \) Other: 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be filled in by the Accident Suicide Suicide
Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month. Day. Year) MD December 27 2011 completed cause of death (Item 23a) (Type, Print) Hanaver Street 3001 South 21225 31. Date filed (Month, Day, Year! Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 N State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Samuel Moore Dec 26, 2011 7:40a M Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner **Baltimore Towson** Gilchrist Center for Hospice Care Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** nth, Day, Year) Nov 23, 1919 Months Days Hours Min. MD 578-14-9973 1 M 2 D F 92 **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. iant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 Yes 2 No Jessup Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. Funeral 20794 9989 Guilford Road 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married ò 1 ☐ Yes 2 🕇 No Baltimore, Maryland 21215-0036 Black Specify 3 Widowed 4 Divorced Completed Year or Dates : If item 27 is marked other than "natur or other traumatic event, the Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Church Minister 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Ermona Henson Randolph Moore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9989 Guilford Road Jessup, MD 20794 Beaula Moore 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Department of P Important: If ite any injury or ot once. emetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Elkridge, Md. Jan 04, 2012 Meadowridge Memorial Park 4 Donation 5 Other (Specify) permit. 22. Name and Address of Facility
Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 21. Signature of Funeral Service Approximate Interval Between Onset and Death 23a. Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final ement Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury attending physician and I for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 XNo 3 Probably 4 Unknown Be Completed neec 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 performed? 2 No 1 🗌 Yes 26. Place of Death (Check only one) filled in by the funeral director, 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🗌 Yes 2. No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 Natural 5 Pending 2 🗌 No 24 hours after death. Funeral Director; Af Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou

To the Fune

completely f (Check only one) 29b. Signature and title of certifier center 26 2011

State

Registrar

recv Us

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

31. Date filed (Month, Day, Yea.

JAN 06

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar 42594 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ RRAN 7:50 AM 2011 Medical acility Name (if not institution, give street and i 4c. County of Death City, Town, or Location of Death Examiner HARWOOD DICE If Under 24 Hrs. 7. Age (In yrs. last birthdav) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 557-91-5800 **Director** 1 🗌 M 2 🎛 F 25 Aug 14, 1986 California Usual Residence of Deced 28a-f show with the Maryland 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🏻 No Maryland Waldorf Charles ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ian "natural", or items 23a or Medical Examiner must be Funeral 6902 Caribou Court 20603 United States death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 Married ò Baltimore, Maryland 21215-0036 within 72 hours after African American 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the 12 Cashier <u>Re</u>tail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Melvin Phillips Bobby Price traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6902 Caribou Ct. Waldorf, MD 20603 Bobby Price / Mother injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 1/5/2012 Woodbine, Maryland Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M any ir MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Physician/ mank disease or condition resulting in death) -n+lamma Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to jor as a consequence of burial-transi and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live Birth 2 Pregnant at time of death 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

• Funeral Director: After this certificate has letely filled in by the funeral director, page 2. autopsy performed 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) \(\text{HO5P1C} \) \(\text{E} \) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending work? 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 3 L 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 52756 -2012

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sig

11-09232 Dwight Parks Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Dwight: aiks		1- For State Registrar	State	or Maryland	•	ificate of D		vientai n		20 l	1 4259
Physic Medical Exam			ne (First, Middle,Last)					Date of Deat Month December		3. Time of Death 1250 hrs
			if not institution, give)	4b. (City, Town, or Loca	ation of Death		4c. County of Death	
			Baltimore Stree				altimore				
Funeral Director		220-78-5 Usual Residence of			ge (In yrs. last			f Under 24Hrs Hours Min		th(MM/DD/YYYY) 9. Bir Foreig 5, 1960 penn	thplace (State or in untry) 15 y I v an i a
any		10a. State	10b. County		10c. City, To	own or Location					10d. Inside City Limits
Maryland 28a-f show	ō	MD			В	altimore	2				1 Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Nu		- 0.		10	f. Zip Code	1000	10	g. Citizen of What Cou	ntry?
with the 11 23a o	ralD	11. Marital Status	Baltimor	e Street 12. Was Deceden	Ever in U.S.	13. Was De	2 J cedent of Hispani	1223 ic Origin? (Sp	pecify Yes or No-	USA 14. Race - Ameri	can Indian, Black,
after death n!", or iten	by Funeral	1 Never Marri	ed 2 Married 4 Divorced		No	If Yes, s	pecify Cuban, Me	exican, Puerto		White, etc.	ek
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Manhal Hygiens. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other transmite event, the Medical Examiner must be notified at once	Completed t	Elementary/Sec		ly highest grade cor College (1-4 or		during most o	sual Occupation (If working life. DO			16b. Kind of Business/I	·
-003 d withi giene. ther th	mo:		(First, Middle, Last)	0		handyn		fother's Name	(First Middle M	various	3
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be C	Allen P	, , , ,						ea Hanke		
MD 21 d 2 should tth and Me in 27 is ma	ဥ		ame/Relationship (T	,	7)					ber, City or Town, State	
e, M and 2 Health item 2		20a. Method of Dis	·			ce of Disposition	(Name of cemeter		Date	Baltimore,	
Baltimore, permit. Pages I as Department of He Important: If ite		4 Donation 5	Cremation 3 X Other Specify:	in state	uio	matory or other p					
Bal(1000	neral Strvice Licens	un	ector	Balt	imore. MI	D 2120	0.1	Baltimore	Street
Physician Medical	U 0		ne disease, or compl ily one cause on ea		the death. D	o not enter the m	ode of dying, such	h as cardiac o	r respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
xaminer		Immediate Cause (or condition resulti		Hanging Oue to (or as a cons	equence of);						Death
		Sequentially list co	nditions, b.								
	mine	if any, leading to in cause. Enter Under (Liseaux or injury)	erlying Cause	Oue to (or as a cons	equence of):						
ansit	Exa	events resulting in		Due to (or as a cons	equence of):						
ox 68760, sub certificate be executed attending physician and or use as the burial - transit	Medical Examiner	UNPENDED		AMENDED #5, per	Inf	g935 1/2	/13 trt				
8760, ifficate be ng physici so the burits	n/Me	IF FEMALE: 23b. Was decedent	pregnant in the	23c. If yes, outcor	ne of pregnar	ncy 2 Fetal de	. —	ctopic pregna	ıncv	23d. Date of delivery Month	ay Year
Box 687 e death certific the attending p cd for use as th	Physician/I	past 12 months		4 Pregnant at	time of death	, - =	(Specify)				.,
हेर्द है	by Ph	Part II. Other signi	ficant conditions		h but not resu	ulting in the under	lying cause given	in Part I.		bacco use contribute to	
duires t									1Yes	2 No 3 Prob	ably 4 Unknown
Records, P.O. I The lar requires that the cate he been signed by the page 2 should be detached	Completed				-				autops perforr	prior to c med? death?	ompletion of cause of
an: The ertificator, pa	امها	25. Was case refer	red to medical	_			26.Place of D			No 1 Ye	s 2 No
'Vita Physici ruthis of	10 B		2 No			R/Outpatient 3	DOA Othe	⁹⁷ 4 Nursin		Residence 6 🗹 Other	Scene
Division of Vital Records, P.O tall or Attending Physician: The law requires that the tall and the death. **All Director: After this certificate his been signed by led in by the funeral director, page 2 should be detac		27. Manner of Deat 1 Natural 2 Accident	h 5 Pending Investigatio	28a. Date of Inju FOUND: Dec 8, 2011	ear) F	8b. Time of Injury OUND: 200 hrs	28c. Injury at 1	1	28d. Describe he Subject hang	ow injury occurred ged self	
Division of Vital Records, P.C. To the Hospital or Attending Physician: The lar requires that within 24 hours after death. To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be deta	Certification:	3 ✓ Suicide 4 Homicide	6 Could not be determined	28e. Place of in	jury - At home		ctory, office buildin		or Town, St	treet and Number or Rui ate) Itimore Street, Baltim	
Di the Hospital thin 24 hours a the Funeral	Medical C	29a. Certifier (Check only one) 2		On the basis of exa						e(s) and manner as state and place, and due to the	
To witin	Me	29b. Signature and	title of certifier	and manner stated.			29c. License nur	mber		29d. Date signed (Mon	th, Day, Year)
		tet	U-	TORRE	ر سر		O.C.M.E.			December 9, 201	1
			ess of person who c nica-Pollak MD			,	W. Baltimore	e Street R	altimore MC	21223	
s	tate	31. Date filed (Mon			r's Signatura						
Reais	trair	AAL	1004014	Museum 1	M	BOOL No.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician/ RUSSELL EMMA 06:19 PM Lau 201 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Calvert Prince Frederick Calvert Memorial Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Novits Day, 1921 Hours Days Min 1 M 2 X MaryTand 90 Director 184-12-4420 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at with the Maryland Director 1 Yes 2X No Prince Frederick MD Calvert 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20678 USA 470 W. Dares BEach Road iral", or items 2 Examiner mus death 12. Was Decedent Ever in U.S Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. 43-4 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify Specify: White "natural", 3 Widowed 4 X Divorced Completed 43-46 the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working (Specify only highest grade completed) Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 librarian education event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H if item 27 is marked ot r other traumatic even Elliott Holdsworth Hutchins Ernestine Stier Dulanev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 1955 Mallard Point Road Prince Frederick, MD 20678 Elizabeth Ridgely/niece 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State netery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) License. Name and Address of Facility tate Anatomy Board 655 W. Baltimore Street 21timore MD 21201 Signature dineral Service 22. Name and Address of Fact State Anatomy Baltimore, MD Director Kona Id 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or head failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition unone Medical resulting in death) as a consequence of week Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami attending physician and for use as the burial-trar that initiated events Hospital or Attending Physician; The law requires that the death certificate be exect Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 2 No ed by the a detached f 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown need 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Hyperlipidemis After this certificate has funeral director, page 2 autopsy performed? Yes 2 No death?
1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 Yes 2 No 1 🗹 Natural 5 Pending 24 hours after death. Funeral Director: A Accident Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie ٥ 29c. License number 29d. Date signed (Month, Day, Year) NIMIT SHAH, MO

State Registrar Nehah/1388

Name and address of person wi

D72608

cause of death (Item 23a) (Type, Print)

MAIPMA PINCE FEDERICE, MO 2007 &

29/2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month December 31, 8:00 PM Physician/ 2011 Albert Strauss Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Center for Hospice Care Towson 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Mir ^{Year}1917 Days Sep 12, 94 Maryland 213-09-7433 Director 1**X** M 2 □ F 10d. Inside City Limits show 10c. City, Town or Location 10a. State 10h. County must be notified at Director 1 No Yes 2 □ No 28a-f Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 5 23a Funeral United States 21209 3021 Fallstaff Road Unit 502 should be filed within 72 hours after death vand Mental Hygiene.
is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. an "natural", or iter Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. White 3

Widowed 4 □ Divorced Year or Dates. WW.II Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Land Developer Land traumatic event, the Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Ida Rodman Isaac Strauss permit. Page 1 and 2 should be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is any injury or other trauonce. 527 Brook Road Towson, MD 21286 David Lloyd Strauss /Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Jan 04 1 Burial 2 Cremation 3 Removal from State Beltsville, Maryland 2012 4 Donation 5 Other (Specify) Chesapeake Crematory Signature of Funeral Service Licensee Name and Address of Facility
Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final .Physiciah/ YPAR BLADDER METASTATIC disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trai Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 SS attending IF FEMALE: 23c. If yes, outcome of pregnancy use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day should be detached for Pregnant at time of death 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion death? autopsy performed 1 Yes 2 24 No 1 Yes certificate 26. Place of Death (Check only one) 25. Was case referred to __edical Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 - No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 27. Manner of Death After t injury 1 Natural 5 Pending 1 Yes 2 No Investigation within 24 hours after death

To the Funeral Director: A

completely filled in by the f Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Pri KROW Mr. 32. Registrar's Signature Date filed (Month, Day, Year State Registrar

Dorothy	Louise	Shepard	
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		1- For State Registrar			Ce	ertific	ate of	Death				Re	eg. No.	<u></u>	J 1	1 7	
Physicia		1. Decedent's Name (First,	Middle,Las	st)							2	Date of Deal	th	Van		3. Time of	
Medical Examin	er	Dorothy Lou	ise S	Shepard	1							December	Day 31, 2	Year 2011	<i>'</i>	1748	hrs
		4a. Facility Name (if not ins	itution, giv	e street and n	umber)		4	b. City, Town	, or L	ocation of	f Death	-	4c	. County o	f Death		
		925 Topview Drive	:					Edgewoo	d				H	larford			
Funeral	7	5. Social Security Number	6. S	ex	7. Age (In yrs	. last birl	hday)	If Under 1	Year	If Under	r 24Hrs.	8. Date of Bir	th (MM/	DD/YYYY)		thplace (Sta	
Director	- 1	215-54-2363	1	M 2X F	61		Yrs.	Months I	Days	Hours	Min.	T 1	1	1050	Foreig		est.
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Au A	ŀ	10a. State 10b. Co			10c, Cit	y, Town	or Locatio	on .								10d. Insid	e City Limits
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than cevent, the Medica	8	Tracey Ray S	hepa:	rd					1	Ines	Mar	ie Kis	е				
ould i Me	의	19a. Informant's Name/Rela	tionship (1	Type, Print)		19	b. Mailing	Address (S	treet a	and Numl	ber or Ru	ral Route Nun	ber, Ci	ity or Towr	n, State,	, Zip Code)	
MD and 2 sho alth and m 27 is	- 1	Michael Burn	s / :	Son		T1	767 (Orchid	Αv	те.,	Apt.	306,	Hol.	lywoo	od,	CA 90	1028
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Baltimore, Permit. Pages I an Department of Hee Important: If itee	- 1	7 117		Removal f			•	morial	C	ana	1_0	5-12	Do	\1 7\ 1 .	~	Mara	Land
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "injury or other traumatic event, the Medical.	- 1	11 11/1	1 1		TU		Mc	Comas	Fu	nera.	l_Hor	ne, P.A	· ·				
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Examiner	- [Immediate Cause (Final dis or condition resulting in dea			ive Atheros		Cardic	vascular	Dise	ase						Į.,	Death
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	<u>.</u>	cause. Enter Underlying Ca	use		E. C. P. Harrison, S. P. Ser.	-										1	
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		(Mul	rlee	M)					C.M				Jan	uary 1, 2	2012		
5 V		30. Name and address of pe		•			141 5			D		204222					
9		Laron Locke MD.			al Examiner		vv. Bal	umore Str	eet,	Baltim	ore, MI	J 21223					
Sta		31. Date filed (Month, Pay.)	ear)	32. R	egistrar's Signa	ture	1										
Registr	ŒΠ	JAN U U CUI	- 14	all the	B. 10	WITE	_										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 12, per fb, g923 1-12-12 sm
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Melvin smith 1'30PM Deamber 28 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Randallstown Season's Hospice NW If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Davs Hours **Director** 212-07-0957 Usual Residence of Decedent 1 **X**M 2 □ F 98 Yrs MD 2/21/1913 or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Randallstown 1 Yes 2 No Baltimore MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? r items 23a or ner must be n ò Funeral USA 21133 3822 Janbrook Road death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian ed other than "natural", or itel event, the Medical Examiner rmed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 № No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry ye 1 and 2 should be filed within 73 t of Health and Mental Hygiene. If item 27 is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Postal Service Mail Carrier 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Adeline Edwards ൧ Bernard Smith traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 3822 Janbrook Road Randallstown, 21133 Melvin Smith, Jr./son injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State Department Important: If any injury or once. Owings Mills, MD 1/9/2012 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest VA re of Funeral Service Licensee 22. Name and Address of Facility 4300 Wabash Avenue March FH West 23a. Part 1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. BAltimore, MD 21215 Approximate Interval Between Onset and Death Immediate Cause (Final Physician) End-Stage Dementia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exami Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): at ending physician If r use as the buria Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death signed by the allending be detached for use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Year Month Day Yes 2 No 1 Yes 2 L 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 page 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be Other:
4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 👿 No ည 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Twingapahu M.O 12/29/11

State

Registrar DHMH 17 Rev 06-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20

6

32. Registrar's Signature

5- Kajapakse, Mio.

JAN 0

31. Date filed (Month, Day, Year)

DOOS7465

5203

Market .

MD 21209

State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ December Mary Jane Stewart Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sinai Hospital of Baltimure Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) **Funeral** Director 1 M 2 XF 212-50-5426 72 Yrs. 1/26/1938 Usual Residence of Decedent Patient Known as Many Jane Stewart 28a-f show 10a. State 10c. City, Town or Location aţ Director notified Owings Mills MD Baltimore 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? ō Examiner must be items 23a Funeral 9315 Edway Circle 21133 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2**X** No o, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐xNo Specify: "natural" 3 ☐ Widowed 4 ☐ Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Johnson Edward Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6401 Jonas Way Baltimore, Debra Glay/daughter MD 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) 1/5/2012 Zion Cemetery! Baltimore, MD 21. Signatury of Funeral Service License 22. Name and Address of Facility 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or conditions) March Funeral Home West Metastatic Sovemous Cell Lung Cancer Physician/ disease or condition Medical Examiner resulting in death) Due to as a consequence of) Sequentially list conditions Due to (or as a consequence or) n any, leading to immediate cause. Enter Underlying Examir The law requires that the death certificate be executed Cause (Disease or injury that initiated events and -trar Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Severe Emphysema, Asthma, Hypertension 1 Yes 24a. Was an page 2 s autopsy has certificate 25. Was case referred to medical To the Hospital or Attending Physician: funeral director, 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 🗌 Yes ည Inpatient 2 ER/Outpatient 3 DOA this 27, Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director; After to completely filled in by the funer 5 Pending □ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Frantitioner: To the certifying Nurse Frantitioner: To the certifying Nurse Frantitioner: To the certifying Nurse Frantitioner: To the certifying Nurse Frantitioner: To the certifying Nurse Frantitioner: To the certifying Nurse Frantitioner: To the certifying Nurse Frantitioner: To the certifying Nurse Frantitioner: To the certifying Nurse Frantitioner: To the certifying Nurse Frantitioner: To the certifying Nurse Frantitioner: To the certifying Nurse Frantitioner: To the certifying Nurse Frantitioner: To the certificity of (Check 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Mann, M.D. RES-000 December 29,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes 2 X No

2011

MD

14. Race - American Indian,

4300 Wabash Ave. Baltimore, MD

23d. Date of delivery

2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No

Approximate Interval Between Onset and Death

Black, White, etc.

Specify: Black

14:50 PM

DHMH 17 Rev 06-2011

State

Registrar

JUSTIN D. MANN, M.D.

JAN 0 6 2012 >

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Sinai Hospital of Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBER 2011 7:10A STEADMAN ODEAL Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min. 1 □ M 2 🖺 F Pennsylvania Director 577-28**-**7700 94 Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4205 Grant Street 20019 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify. 3 ₺ Widowed 4 □ Divorced Black Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Peace Corp other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Evelyn Logan UnKnown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Swiss Ct. Germantown MD 20874 Freda M. Copeland/Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Spe Fort Lincoln Cemetery 1-3-2012 Brentwood, Maryland 22. Name and Address of Facility John T. Rhines Funeral Home 21. Sin ature of Funeral Service/Licens 3005 12th Street NE Washington DC 20017 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician/ difease or condition resulting in death) Medical Du to (or as a consequence of): Examiner ienona Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence Osteonyelitis attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: Ŋο 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Other (specify) ate has been signed by the a page 2 should be detached. 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed Paux 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy autop., performed? No death? 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 ☐ Yes 2 🗷 No Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Medical Certificate: 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation completed filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

2 State

Name and addr

31. Date filed (Month,

JAN O

6 20

Registrar

DHMH 17 Rev 7/2009

ND

400

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sign

D0069065

Frederick, MD 21701

1) .

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene Registrar 42602 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Physician/ B. Smith sadie December 15 20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Medical OWSON Joseph 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours Director 1 □ M 2 💢 F 28a-f show 10d. Inside City Limits 10c. City, Town or Location , at 10a. State Director ıral", or items 23a or 28a-f s Examiner must be notified Pikesville Baltimore 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 21208 illa are Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married "natural", or þ Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify: Specify: 3 ₩idowed 4 □ Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4 or 5+)
5+ Yeavs Education Educatry Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name First, Middle, Last) Inomas Kaphael Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) V. Smith lillage Court Pikesville MD 21208 Woodholme Michael 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Druid Ridge Cemetery Pikesville, MD 12/23/2011 ☐ Donation 5 ☐ Other (Specify) Vaughn C. Greene Flueral Services Signature of Funeral Service Licens Road Randalistown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ęPnysician/ disease or condition Medical resulting in death) Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner resulting in death) Last attending physician for use as the buria Physician/Medical #プイペンジが MS Division of Vital Records, P.O. Box 68760 CERTIFICATION IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month been signed by the a should be detached f g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? 2 🗌 No 25. Was case referred to medica or Attending Physician: 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending within 24 hours are:

To the Funeral Director: After Accident Suicide Investigation 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

— Certifying Marcy Practition or To the best of my in swips as each occurred at the time, date and clarifying and manner as stated. (Check Cartifying Nurse Practitioner: To the best of my knowledge, death on 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 2011 D00518

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day,

Smith, Sadie

7601

Osler Drive, Towson, Maryland 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20

M.D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

		,	For State Registrar	State of Ma	aryland	-	artment of F <i>tificate of E</i>		d Mental Hy	2.0		42603
	Physicia	an/	Decedent's Name (First, Middle)					7001.7	2. Date of Dea	ath Day		3. Time of Death
	Medic Examir	cal	4a. Facility Name (if not institution	Michae aive street and number	·1 Wil	lliam :	Sigman 4b. City, Town, or	Location of De	Dесеп	mber 29,	2011 1	11:14 P.M
-	Exami	iei	3624 Robin A	, 0				Pasadena		4c. County	Anne A	rundel.
	Funeral Director		5. Social Security Number 217 46 2764	6. Sex 7. Age		st birthday)	If Under 1 Year Months Days	If Under 24 H Hours M	lin. (Month, Day	y, Year)	Country)	
		1	Usual Residence of Decedent	1 LA W Z L F	60	Yrs.			02/22	/1951		fornia
	aryland a-f shi fied al	ctor	10a. State 10b. County Maryland Ann	Amundol	,	, Town or Loc Pasade					10d.	. Inside City Limits 1 ☐ Yes 2 ☐ No
	he Ma or 28	Dire	10e. Street and Number	ne Arundel		Pasaue	10f. Zip Code			10g. Citizen of V	What Country	
	s 23a nust b	Funeral Director	3624 Robin Ai	r Court			2	21122		U.S.		
36	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		11. Marital Status 1 Never Married 2 X Man	If Yes, Give		l†	Vas Decedent of His f Yes, specify Cubar	n, Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)		e - American I k, White, etc.	
9-9	hours and matura	letec	3 Widowed 4 Divorced	Year or Dates.		16a. Deced	lent's Usual Occupa	ation		16b. Kind of Bu	WILT	
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d 21	ed with Hygier other 1 ent, th	Be C	12th 17. Father's Name (First, Middle, L	ast)		1.1	. Directo		Name (First, Middle,			ryland
/lan	d be fill Vental arked (attic evi	10		lomer Alvy Si	gman				ice Vilett		,	
, Maryland 21215-0036	and 2 should be filed within 72 Health and Mental Hygliene. tem 27 is marked other than " ther traumatic event, the Med	77	19a. Informant's Name/Relationsh Gail Tutko /				g Address (Street a Robin Ai		Rural Route Number t Pasa	r, City or Town, Si adena,M		
ore	of = o		20a. Method of Disposition 1 X Burial 2 Cremation		cei	emetery, crem	sition (Name of natory or other place	' ' ' ' ' ' ' ' '	Date /04/2012	20c. Location -	-	
Baltimore,	교환원들		4 ☐ Donation 5 ☐ Other (S		Hol		SS Cemete: Name and Addres	T y		Baltimo		
ă	Depar Impor any ir	1	Pono	Monde	ze	4	001 Ritch	hie Hig		ltimore,	Mary1	P.A. Land 21225
	Physician	3 7	23a. Part 1. Enter the disease, or shock, or heart failure. List o Immediate Cause (Final disease or condition	complications that cause only one cause on each line	the death.	. Do not ente		g, such as card	iac or respiratory arm	est,	Int On	oproximate terval Between nset and Death
1	Medical Examiner		resulting in death)	Due to (or as a	conseque	ence of):						
		iner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	conseque	ence of):						
3	ecuted and I-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	CODSEGUE	ence of:						
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8760	tificate ng phy	Med	IF FEMALE:	_ u							- 12	
Box	death	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live Birth 2 Pregnant at 9 Unknown	2 Fetal	death 3 🗌	Ectopic pregnancy Other (specify)	у		23d. Date Mor	te of delivery nth Day	y Year
P.O.	that the	by Ph	Part II. Other significant condition	ns contributing to death bu	ut not resul	Iting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use contri		
rds,	requires been sig should b	sted							_ 1 🗆 Y	Yes 2 No	3 Probabl	ly 4 🗆 Unknown
Division of Vital Records,	The law ate has page 2	Completed							24a. Was a autop perfor 1 ☐ Yes	rmed? p	Vere autopsy forior to complete leath?	findings available etion of cause of
ita	sician: certific irector	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:			Otho	ace of Death (Ci		/		
of V	ing Physician: After this certific funeral director,	te: 70	27. Mann Death	28a. Date of injury	y 2	R/Outpatient 28b. Time of	28c. Injury	4 ∐ Nursing ⁄at	g Home 5 Resid	lence 6 Other	-	
noi	eath. or; Aft the fur	Certificate:	1 Natural 5 Pendin 2 Accident Investig 3 Suicide 6 Could r	gation		injury		? Yes 2 ☐ No				
ivis	lor Att after d Direct d in by		4 Homicide determi		ry - At hom . (Specify)	ne, farm, stree	et, factory, office		28f. Location (Si City or Town	treet and Number n, State)	r or Rural Rou	ste Number,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	(Check 2 \square Medical E	Physician: To the best of n xaminer: On the basis of ex	kamination a	and/or investig	gation, in my opinior	n, death occurre	ed at the time, date ar	nd place, and due	to the cause(s	s) and manner stated.
	To the within To the compl		only one) 3 ☐ Certifying 29b. Signature and title of certifier	Nurse Practitioner: To the	best or my	/ knowleage,	death occurred at the 29c. License			ne cause(s) and ma 29d. Date signed		
			X	2	MI)	700	1630	83	12-39	0-2	011
_	5		30. Name and address of person v	Horiba		225	Creen	2 St	S9D 3	Beltine	ore, y	(05/15 CI
	Stat Registra	le l	31. Date filed (Month, Day, Year) -	5	r's Signatur	La	what					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2011 December 3:00 Louise Florence Virginia Snyder 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Frederick 207 S. Jefferson St. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Months Days Hours 1 □ M 2 😾 F Aug 16, 1924 Maryland 87 219-12-2374 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 □Yes 2√□No Frederick Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21701 USA 207 South Jefferson Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ∐Yes 21X No Specify: Specify: white 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) registered nurse healthcare 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carrie Estelle Mossburg Gilmer Tobias Castle Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 207 S. Jefferson Street Frederick MD Ralph R. Snyder/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 21. Signature of Funeral S. ry e License Rona Approximate Interval Between Onset and Death 23a. Part . Enter the disease, or complications that caused the death. shock or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final 573 case disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ons contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Joint Messese 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 2 LINo 1 TYes 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred

Physician /Medical **Examiner**

permit. Pages 1
Department of H
Important: If Ite
any Injury or ot

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10a. State

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Certification:

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show unty or other traumatic event, I'm Muffich Exprinter mant be a milling at uny or other traumatic event, I'm Mufich Exprinter mant be a milling at

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

Division of Vital Records,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

9 Unki	nown
Part II. Other	significant condition
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11	Degen
	0

25. Was case referre examiner?	d to medical o
27. Manner of Death	
1 Natural	5 Pending

5 Pending investigation

6 ☐ Could not be

28b. Time of 28a. Date of Injury (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, JAN 0 6 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42605 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) December 28, 2011 Physician/ 2:00 Anna Caroline Scholl Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Baltimore Towson Edenwald 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** (Month, Day Year) 6 Days Hours Min. Pennsylvania 1 □ M 2 🛛 F **Director** 95 009-01-8859 Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State Director 1 🗆 Yes 2 🎦 No Towson MD Baltimore 10f. Zip Code 21286 10g. Citizen of What Country? 10e. Street and Number 800 Southerly Rd #101 Funeral Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S 11. Marital Status Black, White, etc. Armed Forces?

1 Yes 24 No 1 X Never Married 2 Married þ 1 Yes If Yes, Give Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify. Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 12 healthcare public health nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Emma Haas Peter Levi Scholl 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2539 Maple; Northbrook, IL 60062 19a. Informant's Name/Relationship (Type, Print) Susan S. Bentley - niece 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Coard Funeral Stryice Ligens 655 W. Baltimore St; Baltimore, MD 21201 Approximate Interval Between Onset and De art 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each et and Death Immediate Cause (Final Phy ician/ resulting in death)) Medical Due to (or as a conseque **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a cons Exami Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnar 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year be detached for 4 Pregnant 9 Unknown Pregnant at time of death ☐ Yes ∠ ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 1 Tes the Hospital or Attending Physician: The law requires Division of Vital Records, Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy After this certificate has 1 🗆 Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Hospital: Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA Man or of Death Natural funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident within 24 hours after death

To the Funeral Director: /
completed filled in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examine: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 only one Month 29b. Signature and title of certifie 30. Name and address of person who of

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 20c per fh 9923 1-6-12 vt
per Amend Items 208 tate of Maryland 110 20 12 dnb

For Amend Items 208 tate per Th, 8923 1,01710 20 12 dnb

Certificate of Death 42606 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Helen Margaret Thompson 2:55 PM 2011 December Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Towson Gilchrist Hospice Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, **Funeral** Days Min. Months Hours **Director** 1 M 2 TXF 215-07-7239 95 Yrs. June 15,1916 Maryland Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1X Yes 2 ☐ No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŪSA Funeral 1019 Haverhill Road 21229 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married 2 🔀 No þ Yes Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3₩Widowed 4 □ Divorced If Yes, Give Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) United Credit Bureau Book Keeper Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ellen Margaret Carr Edgar Mobley Grimes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1019 Haverhill Road Baltimore Maryland 21229 Mary Jo Thompson-Daughter Saltimore, 20b. Place of Disposition (Name of UKNemetery, crematory or other place) 20c, Location - City or Town, State
UKN Crownsville, MD 20a. Method of Disposition Date HVN 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville Vet. Cem. Jan. 10,2012 Arbutus, Md. 21. Signature of Fine al Service Lice 22. Name and Address of Facility Ambrose Funeral Home Inc. 1328 Sulphur Spring Road Arbutus Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Mars disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death signed by the at d be detached fo Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ discuse Vouscerles Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? w discise 24a. Was an presovascul cate has page 2 s autopsy performed? 1 Yes 2 No this certificate 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence Hospital: Other (Specify) WUSPICE 2/2 No ပု 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No al or Attending P s after death. Il Director: After the Certificate: 28d. Describe how injury occurred injury 1/ Natural 5 Pending 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital of within 24 hours at To the Funeral D Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 🗌 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D58303 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARON 1 CHANES M 6701 N. Chances ST TOWSON MD 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Day 30, 201 Physician/ Medical Facility Name (if not institution, give street and number) Examiner 9. Birthplace (State or Foreign If Under 8 Date of Birth Funeral Min July 10 1 □ M 2 🔯 F Maryland 1923 88 Yrs 215-14-8869 Director Usual Residence of Decedent 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b, County be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 USA 701 Edmondson Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 black 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Year or Dates. 15 Decedent's Education 16a Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 10 0 housewife own home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ David Crawford Christine Mason permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic to injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria O'Neal/daughter 5918A Johnnycake Road Baltimore, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🛛 Other (Specify) in state Signatu weral Sawa Wade State and Address of Facility oard 655 W. Baltimore Street MD Baltimore Part 1. Seter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atheros Pnysician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Day in the past 12 months?

1 Yes 2 No Month for Pregnant at time of death signed by the at d be detached fo g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 s has 1 ☐ Yes 2 ☐ No Yes this certificate 25. Was case ferred to medical examiner? 26. Place of Death (Check only one) funeral director, Be 2 XNo Other: ပ 1 Tyes ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, determined Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, Year)

1AN 0 6 2012 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 42608 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 28, YVONNE BRUNHILDA TRINKWATER 2011 10:32P ^M December Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 109 Longwood Road Baltimore N/ASocial Security Number 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 8. Date of Birth **Funeral** (Month, Day, Year) Months Days Director 088-22-6826 1 🗆 M 2 🗶 F 82 July 12, 1929 New York Usual Residence of Decedent show 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State must be notified at Director 28a-f 1 X Yes 2 □ No Maryland N/ABaltimore City 10e. Street and Number or 10g. Citizen of What Country? , 23a Funeral 21210 116 Cross Keys Road, Apt C USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Armed Forces? Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify White If Yes, Give Year or Dates 'natural", Completed 3 Widowed 4 X Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. College (1-4 or 5+) **5+** Nursing Elementary/Secondary (0-12) the Nursing College Instructor other Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Unknown Gretchen Trinkwalter it of Health and N. If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109 Longwood Road, Baltimore, Maryland 21210 Yvonne Ottaviano, M.D. (Daughter) 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Green Mount Crematory 12/30/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signat Of Fune Servi Auce ser

Martin D. Lawson MTTCHELL-WIEDEFELD FUNERAL HOME INC 6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner atheroscu por *(ardiovasaular* Sequentially list conditions. Examine day, leading to immedicause. Enter Underlying Cause (Disease or injury Due to for se a consequence of burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last been signed by the attending physician should be detached for use as the buria Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Month Year 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use pontribute to the cause of death? Be Completed by Division of Vital Records, 2 V No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed perform 1 Yes 2 No After this certificate 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner?
1 \(\sum \) Yes 2 \(\sum \) No Other: 4 Nursing Home 5 Presidence 6 Other (Specify) Hospital 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred ☑ Natural 5 Pending injury Investigation Accident 24 hours after death Funeral Director: filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier ns RyapameM. D 29d. Date signed (Month, Day, Year) 29c. License number DOUS 7465 12/29/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. S. Ruypal H. M. D. 783. Sm. M. Baltimore 2835 Smin HV 5203 32. Registrar Signat State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011 42609 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mar 2 ear 11 alentik Physician/ 10:16 AM December Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Assisted Living -us If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 1927 Czechoslovakia 8. Date of Birth (Month, Day, Yo Feb. 24, Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min. Year) Months 1 M 2 K F Hours 84 077-24-4117 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State must be notified at Director 1 Yes 2x No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 23a Funeral 6 Plateau Ct 21228 USA or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11, Marital Status Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🔀 No Specify: White 3 X Widowed 4 □ Divorced or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Suzanna Alexander Hrabik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 6 Plateau Ct., Catonsville, MD. 21228 Rosemary A. Warwick (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or oth 1 K Burial 2 Cremation 3 K Removal from State Calverton Nat'l Cem. 1/4/12 Calverton, New York 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ementi disease or condition Medical resulting in death) Due t or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine kinson Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed -tran and Due to (or as a consequence of): attending physician a for use as the burial-Be Completed by Physician/Medical nemia Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 Y No

9 Unknown 5 Other (specify) signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an performed? Yes 2 X No sfunction Ctai Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Assisted Hospital: Other: 1 ☐ Yes 2 💢 No 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 1 X Natural 5 Pending 1 Tyes 2 🗌 No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, B-enson 3320 MD 32. Registrar' State Registrar

State of Maryland / Department of Health and Mental Hygiene 42610 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary Imelda Witt 11:30A M December 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Atlantic General Hospital Berlin Worcester 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, May 12, Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours **Director** 86 219-18-2403 May Usual Residence of Decedent shov e filed within 72 hours after death with the Maryland tital Hygjene. ed other than "natural", or items 23a or 28a-f shor event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Director MD Catonsville Baltimore 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21228 USA Funeral 311 Sunshine Place Apt E 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by White Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Pavrol1 Bookkeeper Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F မ Elizabeth Lucille Allen t. Page 1 and 2 should be f tment of Health and Menta tant; If item 27 is marked ijury or other traumatic ev Edmund Joseph Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. Salt Grass Road; Ocean Pines, MD 21811 David Witt, III Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State New Cathedral Cemetery 1/5/2012 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 2. Name and Address of Facility Sterling Ashton Schwab Witzke uneral Home of Catonsville, Inc. 630 Edmondson Avenue; Catonsville, MD 21228 210M 23a. Part 1. Enter the disease, or complications that caused the death. D. shock, or heart failure. List only one cause on each line. enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter or denying Examine Due to (or as a consequence of): burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): Physician/Medical that the death certificate be the 5/12/1925 phy as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Box (3 Ectopic pregnancy signed by the atte in the past 12 months? 5 Other (specify) Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician: The law requires 2 No 3 Probably 4 Unknown Records, Completed 0 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy hours after death.

Jueral Director: After this certific

filled in by the funeral director, Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 2 1 No 1 🗌 Yes 1 Dinpatient Certificate: To 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28d. Describe how injury occurred Natural 5 \square Pending М 2 🗆 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State within 24 hours a the Bospital Medical Vertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Configure Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed (Check 3 29b. Signature and title of 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print 0 U gistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

12/31/2011

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DO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year December 27 2011 Physician/ Glen Wennberg 1403 PM Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Rockville Shady Grove
5. Social Security Number Montgomery Advertist Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State of Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Funeral Months 339-18-4029 Director 1 □ M 2 F July 20, 1922 Maryland 89 Usual Residence of Decede r 28a-f show notified at 10d. Inside City Limits 10a. State 10c. City. Town or Location **Funeral Director** 1 Yes 2 X No Rockville MD Montgomery 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ms 23a or must be n 20850 USA 9833 Veirs Drive #2 items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 9 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: white "natural" 3 XWidowed 4 Divorced hand Mental Hygjene.

It is marked other than "natural" material. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk College (1-4 or 5+) Elementary/Secondary (0-12) 0 <u>clerical</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frieda Sarah Kadow Harry Whitteker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. Melanie Mercer/daughter 9478 Fort Stauffer Road Green Castle, PA 17225 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) Signatu Funeral Service icens e State Anatomy Board 655 W. Baltimore Street Virector | <u>Baltimore, MĎ 21201</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physicien/ andia disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Heart Failure 1 Yes 2 No 3 Probably 4 Unknown Chronic 24b. Were autopsy findings available prior to completion of cause of death? Atrial 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \sum Nursing Home 5 \sum Residence 6 \sum Other (Specify) မ 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) within 24 hours after deau..

To the Funeral Director: After th 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b Time of Certificate: 28d. Describe how injury occurred Natural Accident Suicide 5 Pending Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ecember 27,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Cor Richaille, MD 20850 9901 MD

State Registrar

B

1100

27

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dec 28, 2011 **Physician** 11:18p M **Evelyn Wallace** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner Baltimore** Towson **Manor Care Ruxton** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours Min. Months 1 M 2 DM MD 93 Director 216-12-9594 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show r than "natural", or items 23a or 28a-f show 1 ☐Xes 2 ☐ No **Baltimore** Director **Baltimore** MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21207 U.S.A. 5100 Belleville Avenue Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: Specify: Black 3 □ Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Spring Grove Hospital Nurse 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental I Mabel Patterson **Howard Patterson** other traumatic မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 Baltimore, MD 21229 of Health 717 Wildwood Parkway. Trinita Blackston 3altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State Department o Important: If any injury or once. <u>+</u> 5 Jan 05, 2012 Laurel, Maryland **Maryland National Park** 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fawure. List only one cause on and line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter the carrier Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) Box 68760. physician Physician/Medical as attending IF FEMALE use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 힏 Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.0. the detached 9 Unknown 9 Unknown as been signed by 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Hinknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed? certificate | 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Division Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier To the Hosp within 24 hou To the Funer completely fil Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number completed cause of death (Item 23a) (Type, Print) 118 Suite 2005 1800 01071209 30. Name and additess of per 7101 01 31. Date filed th, Day, 3 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Wilbert L. Washington Dec 28, 2011 6:48am м Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** N/A Joseph Richey Hospice, Inc. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 M 2 D F Days Min. th, Day, Year) Apr 1, 1938 213-34-3890 73 MD. **Director** Usual Residence of Deced 28a-f show 10a. State the Maryland 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 Yes 2 No MD **Baltimore City Baltimore** 10e. Street and Number P 10f. Zip Code 10g. Citizen of What Country? must be i Funeral 4825 S. Williston Avenue 21229 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Xray Techician Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Leonard Rich Isabella Cooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Celestine E. Washington 4825 S. Williston Avenue Baltimore, MD 21229 Department of Health Important: If item 27 any injury or other tronce, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ■ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Jan 03, 2012 Lansdowne, MD 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cemetery Name and Address of Facility
Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the blsease, or complications that vaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exam signed by the attending physician and Ideached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Wilbert Washington 12/28 lie 6 Jun Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DIABETES MELLITUS - TYPE 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director, After this certificate has been siç completely filled in by the funeral director, page 2 should to 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No ESSENTIAL LYPERTE USION 24a Was an autopsy performed? Yes 2 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) MIT. HISSINGE ၉ 1
Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) JAN 0 6 2012 32. Registrar's State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DECEMBER 24 2011 Physician/ 10:50 AM ATONGNONG LUCAS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S 10000 RIDGE STREET T.ANHAM 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Social Security Number . Age (In yrs. last birthday **Funeral** DEC 25 Min. 1 ₺ M 2 🗆 F Months Days Hours CAMEROOM 1958 53 Director 454-79-8717 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 √Yes 2 ☐ No MD PRINCE GEORGE'S LANHAM 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ò permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or amy njury or other traumatic event, the Medical Examiner must be a once. Funeral 20706 USA 10000 RIDGE STREET Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. δ 1 Never Married 2X Married Yes Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2X No Specify: If Yes, Give Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) GOVERNMENT TEACHER 5+Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 ONANGO ATONGNONG ROSE ENDAH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10000 RIDGE STREET LANHAM, MARYLAND SOPHIA ATONGNONG/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OSHIE BAMENDA, CAMEROON 1/27/12 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 7474 23a. Part 1. Enter the gise shock, or heart failur Immediate Cause (Final disease or condition resulting in death) isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate e. List only one cause on each line Interval Between Onset and Death Physician/ Medical Due to (or as a * onsequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Pregnant at time of death been signed by the a should be detached to g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page 2 performed? death? 1 ☐ Yes 2 ☐ No this certificate Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify Hospital: ၀ 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Medical Certificate: After injury 1 X Natural 5 Pending Accident Investigation within 24 hours after death

To the Funeral Director: A
completed filled in by the f 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature d title of certifi 29d. Date signed (Month, Day, Year) MD039262 JANUARY 4, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3300 WASH DC 20001 ST NW #

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print In Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

	State of Maryland / Department o 1- For State Registrar Certificate o		4261						
Physician/ edical Examiner	1. Decedent's Name (First, Middle,Last) Albertas Audinis	Month Day Year	of Death 2 hrs						
	4a. Facility Name (if not institution, give street and number) 863 West Lombard Street Apt 3	4b. City, Town, or Location of Death Baltimore 4c. County of Deeth							
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 579-29-6118 1 M 2 F 58	If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (s. Months Days Hours Min. 06/13/1953 Foreign Lit Country)	State or thuania						
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the Maryland a or 28a-f sh tified at once Director	10e. Street and Number 863 West Lombard Street Apt 3	10f. Zip Code 10g. Citizen of What Country?							
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b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 23a-f she transmatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	1 Never Married 2 Married Armed Forces? If \(1 \) Yes 2 \(\) No \(3 \) Widowed 4 \(\) Divorced If Yes, Give Year or Dates: \(1 \)	/es, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. White Specify:	гe						
5-0036 ed within 72 hours of the family other than "natural the Medical Exami	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Warehouse Worker 16b. Kind of Busing most of working life. DO NOT use retired) Warehouse Worker								
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MD 21215-003 12 should be filed within the and Mental Hygiene. 127 is marked other the unartic event, the Mediumatic or Be Comp		g Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod audiskiu 87-10 Panevezys Lithuani							
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Atlantic	sition (Name of cemetery, Date 20c. Location - City or Town, St ther place)	tate						
altim mit. Pa partmen portant ury or	4 Donation 5 Other Specify:	Name and Address of Facility Simplicity Crem & Fur							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter	nomas Allen PA 7090 Ridge Rd Hanove	er MD						
Physician /Medical xaminer	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Between	een Onset and Death						
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial—transiedical Certification: To Be Completed by Physician/Medical Ei	past 12 months?	etal death 3 Ectopic pregnancy 23d. Date of delivery Month Day ther (Specify)	Year						
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F, P.O irres that to signed by the detact		1 ☐ Yes 2 ✔ No 3 ☐ Probably 4	Unknown						
Division of Vital Records, tal or Attending Physician: The law require is after death. al Director: After this certificate has been signed in by the funeral director, page 2 should be striffication: To Be Completed		24a. Was an 24b. Were autopsy fin autopsy performed? 1 Yes 2 V No 1 Yes	ndings available on of cause of						
tal Recina The certificate ector, page	25. Was case referred to medical examiner?	26.Place of Death (Check only one)							
ing Physic ing Physic After this uneral dire	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatier 27. Manner of Death 28a. Date of Injury 28b. Time of								
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Division o spital or Attending tours after death. neral Director: Aft filled in by the fune Certification:	3 Suicide 6 Could not be determined (Specify)	pet, factory, office building, etc. 28f. Location (Street and Number or Rural Route or Town, State)	e Number, City						
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ	urred at the time, date and place, and due to the cause(s) and manner as stated. ation, in my opinion, death occurred at the time, date and place, end due to the cause((s)						
¥.248	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day,	Year)						
	N-VL-	O.C.M.E. December 29, 2011							
HV	30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 906	W. Baltimore Street, Baltimore, MD 21223							
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	·							

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10 DECEMBER 31,2011 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BAZIMORE-WASHINGTON MEDICAL CENTER BURDIE ANN ARUNDE 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛣 F 10 4 1936 75 Min 34 Director 212 4510 Usual Residence of Decedent Show 3a or 28a-f shov t be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Orchard Beach Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a must 21226 7912 Sea Breeze Drive U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 0 ð 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: "natural" Completed 3 X Widowed 4 ☐ Divorced White permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 Anne Arundel College (1-4 or 5+) Custodian County School Board Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward August Wolf Sarah Louise Connelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21226 7912 Sea Breeze Dr. Sandra Pease - Daughter Orchard Beach, MD Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory 1/4/2012 Baltimore, 4 Donation 5 Other (Specify) . Signature of Euperal School Licensee 22. Name and Address of Facility GJ Gonce Funeral Home, PA 160 Riviera Drive Pasadena, MD 21122 169 Riviera Drive 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ SCALIC SHOCK 3 DA45 Medical resulting in death) Examiner URINARY TODOT INFECTION 2 NAQ 4 Sequentially list conditions Physician/Medical Examiner than, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last ate has been signed by the attending physician and page 2 should be detached for use as the burial-trans Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be within E4 hours after death.

To the Furnaral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No Pregnant at time of death 5 Other (specify) 1 | Yes 2 | g | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 ☐ Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 📉 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DQA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Oricomm re crowb boar 40 D0065+1A NECEMBER 3175011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GIANGRECO 301 HOSPITAL DRIVE, CLENBURNIE, MD 20161 JAN09 Registrar

11-09352 William Frederick	1			or Print in Bl e of Maryland	/ Depar		ealth ar			egibl	20		1 4261
Physiciar Medical Examin	1/	1. Decedent's Na	m Freder	ast) ick Bauer					2. Date of D Month Decemb	eath			3. Time of Death 1125 hrs
			(if not institution,	give street and number)	1		ity, Town, o	r Location of De		4	c. County of Baltimore		
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5-0036 led within 72 hours after styling the whole than "natural", the Medical Examiner		Elementary/Se		College (1-4 or 5	5+)		awyer	e. DO NOT use r	etired)	1	egal		
more, MD 21215-0036 Pages 1 and 2 should be filed within 7 tent of Health and Mental Hygiene. The Health and Mental Hygiene. The Pool other than a strength of the charteners of the Health of The Pool Connections.		Will	e (First, Middle, La Liam F. B	auer Jr			dint		ellenber	, Maider rger	Surname)		unk
and sho	L	0.C.M.		(Type, Print) Bauer/Siste	er	19b Mailing Add 188 Ho	ress (Stre llen k Balt:	et and Number of Kd. Ball Linore St	r Rural Route N Limore , reet Ba	Md,2	1212 ^m	State,	Zip Code)
Baltimore, M permit. Pages I and 2 Department of Health Important: If iten 2 injury or other traus	1	0a. Method of Di 1 Burial 2 4 Donation		Removal from Sta		ce of Disposition matory or other p		metery,	Date	20c.	Location - (ity or T	own, State
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Examiner	0	r condition resul	ting in death)	Due to (or as a conse		Idiovasc	GIGI	DISCASC	-				
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50, te be exec sysician a burial - t	200	X UNPENDE	D [AMENDED 9, 12 & ME, g92 23c. If yes, outcom	<u>3 1-13</u>	<u>-12 sm</u>	19a-b	,22,23a	pt.II,				
sion of Vital Records, P.O. Box 68760, trending Physician: The law requires that the death certificate be executed death. ctor: After this certificate las been signed by the attending physician and y the funeral director, page 2 should be detached for use as the burial - transit action: To Be Commisted by Physician/Medical Expansion: To Be Commisted by Physician/Medical Expansion	23			1 Live birth 4 Pregnant at	time of death	2 Fetal de		Ectopic preg	nancy	23	d. Date of d	Da	ay Year
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Records, The law requires ficate las been sig- spage 2 should be Completed										opsy form <u>ed</u> ?	pri- de:		opsy findings available impletion of cause of
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Sion of creating death ctor: After funer y the funer: afficure: af		Natural Accident	5 Pending Investiga	(Month, Dey,Ye	ear)			Yes 2 No					

Division
To the Hospital or Attendia
within 24 hours after death
To the Funeral Director: A
completely filled in by the fu

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier Funely Southell, Ma)
30. Name and address of person who completed cause of death (Item 23a)

6 Could not be

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year) December 13, 2011

28f. Location (Street and Number or Rural Route Number, City or Town, State)

OGME

Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

State Registrar

Medical Certification

28e. Place of Injury - At home, farm, street, factory, office building, etc.

29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

One)

Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s).

3 Suicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Robert Benjamin Bowie 2011 12/26/ P M 6:52 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington Adventist Takoma Park <u>Montgomery</u> Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country)
S.C. **Funeral** 7. Age (In yrs. last birthday) Hours Min. 047087 1 X M 2 D F 247-32-3261 Yrs. Director 90 Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Directo D.C. Washington 28a-i 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1225 Gallatin Street NE 20017 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify: "natural" Specify: Black 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the I Chauffeur National Bank 7th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Page 1 and 2 should be filk tment of Health and Mental tant: If item 27 is marked o ပ္ Ephrom Bowie Rosetta Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (son) Robert B. Bowie, 1002 S. Lumber St., Allentown, PA. 18103 Jr. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lincoln 01/03/12 Brentwood, MD 21. Signature of Funeral Service Licenses 420 H St.NE 22. Name and Address of Facility B.K. Henry Funeral Home Wash.DC.20002 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Exami sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Year Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>6</u> Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 2 2 N 1 Yes 2 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 🙀 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Ducember 27,2011 146948 and address of person who completed cause of death (Item 23a) (Type, Print) 3415 HAMILTON ST HYATTSVILLE MD 20782 TEE IMD 31. Date filed (Month, Day, Year)
JAN 0 9 2012 32. Registra State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Year 28 PM 201 Medical Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** N/A AltIMORE If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min 0371 Pay 1 🖳 M 2 🗆 F S.Carolina 1920 215-12-3763 Director 91 Usual Residence of Decedent or 28a-f show e notified at 10a, State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1

Yes 2 □ No MD N/A Baltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? r items 23a or iner must be r ō Funeral 3821 Roland View Ave. 21215 U.S.A. within 72 hours after death "natural", or iten edical Examiner n 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican. etc. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes. Give Specify: Black 3 XWidowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) 12th Grade College (1-4 or 5+) Meat Packer Geotze Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Waymond Boyd Willie Williams traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health item 27 Dwight Thomas (nephew) 3821 Roland view Ave., Baltimore, MD21215 other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit, Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State on-site Crematory 01/09/12 4 Donation 5 Other (Specify) Baltimore, MD Signature of Funeral Service Licensee Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, I PA MD21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician. MENE,A disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to miniculate cause. Enter Underlying Cause (Disease or iinjury Due to (at as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran: that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant
9 Unknown Day Month Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes Be 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Hospital: Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No injury 5 Pending 2 Accider
3 Suicide Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signat 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year,

DHMH 17 Rev 7/2009

rson who completed cause of death (Item 23a) (Type, Print)

3

Verry	(Cooper	
11-09803		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.	
Unk Unk		State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. 2	4262
Physicia	an/	1 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Til	me of Death
Medical Exami	ner	Jerry Cooper December 29, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	546 hrs
		3707 Sixth Street Brooklyn	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace 2.1.5 4.6 7.7.4.9 Min. 0.0 / 3.9 / 4.0.4.6 Foreign	
Director		215-46-7748 1 M 2 F 65 Yrs. Months 65 100	MD
any .		Usual Residence of Decedent 10c. City, Town or Location 10d. 10a. State 10b. County 10c. City, Town or Location 10d.	Inside City Limits
and show nce,	ò	Brooklyn 1	Yes 2 No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 10f. Zip Code 21225 USA	
n with t			ndian, Black,
or death	Funeral	1 XNever Married 2 Married 1 X Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 966-68 1 Yes 2 X No specify: Specify: White	
urs afte tural"	d by	or Dates:	
6 172 ho an "na cal Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) Congatanase of working life. DO NOT use retired)	t i an
-003 I withir giene. ther th	omo	10 yrs Laborer Construct 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	LIOII
21215-0036 and be filed within 7 Mental Hygiene. marked other than	Bec	Gilbert Cooper Sr Lorraine Purdy	
MD 21 d 2 should dth and Me n 27 is ma	ဠ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip C Paula Cox Sister 2749 Marbourne Ave Baltimore MD 212	
e, M I and 2 Health item 2		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town,	, State
MOF Pages nent of nat: If		1 Burial 2 K Cremation 3 Removal from State Atlantic Crem 4 Donation 5 Other Specify: Atlantic Crem	ie MD
Baltimore, permit. Pages 1 an Department of the Important: If ite		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simplicity Crem & Fu	un Serv
Physician			proximate Interval
Medical ≟xaminer	- 4	failure. List only one cause on each line. Immediate Cause (Final disease a. Cutting wound of arm and Narcotic Intoxictation	tween Onset and Death
		or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of):	
1	miner	Sequentially list conditions,	
d d	2	events resulting in death) Last Due to (or as a consequence or).	
executed an and al - transi	edical E	d	
	Medi	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery	
Box 68760, the death certificate be execute the attending physician and red for use as the bunal - trained - trai	cian/M		Year
Box death he atter	Physic	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify)	
P.O. es that the igned by the detache	by P		
duires quires sen sign			
n of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by funeral director, page 2 should be detach	Completed	autopsy prior to comple performed? death? 1 ✓ Yes 2 No 1 ✓ Yes	etion of cause of
n Re n: Th ruffcat tor, pag	ပ္ပ	25. Was case referred to medical 26.Place of Death (Check only one)	2 No
Vita	9 8	examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other Scen	ne
on of ading P th. : After e funer	<u></u>	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Fd 12-29-11 lumknorm 1 Yes 2 X No Subject took drug and	d cut self
Division Hospital or Attendi 24 hours after death. Funeral Director: /	Certification	Accident Investigation Accident	
Div spital o	Cert	3 X Suicide Could not be determined Could not be deter	St.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	se(s)
To cor	Me	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Date signed)	ay, Year)
-11		Caroe Hallan O.C.M.E. December 30, 2011	
(pand		30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
	ate		
Regist	rar	I SHILL OF THE TOP OF THE PARTY	

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physici		1. Decedent's Name (First, Middle, Last) 2. Date of Death Anoth Double State Control of the C	e of Death
Medical Exam	iner	RODELC D. Tellell	42 hrs
		4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital 4d. County of Death Baltimore N/A	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace ((State or
Director		Usual Residence of Decedent No. Months Days Hours Min.	IC
ku*			side City Limits
Maryland 28a-f show d at once.	or	MD N/A Baltimore 1½	Yes 2 No
Maryl - 28a-1	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
th the 23a or		old by carred hye si	
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f she numatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1	an, Black,
ırs aftı tural" ıminel	d by	3 Widowed 4 Divorced If Yes, Give Yeer 1 Yes 2 No specify: Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry	
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003(within iene.	ртр	11th Grade Warehouse Worker Westin hous	e .
21215-0036 and be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Co	17. Father's Name (First, Middle, Last) Joseph Ferrell 18. Mother's Name (First, Middle, Maiden Surname) Catherine Degrafenreid	
212 212 21d be Menti mark	To B	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coc	de)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examines		Beverly Ferrell(wife) 820 S. Canton Ave. Apt 3M, Balto., M	ID21229
or Heal If iter		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, S crematory or other place)	itate
Baltimore, permit. Pages I ar Department of Hee Important: If ite Injury or other tr		4 Donation 5 Other Specify: On-site Crematory Oloo 17 Baltimore, M	
Ball permit Depar Impo		21. Signature of Funeral Service Licensee 2. Signature	A
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Appro	oximate Interval
/Medical Examiner		failure. List only one cause on each line Immediate Cause (Final disease a. Right Hemothorax	een Onset and Death
LAMITTE		or condition resulting in death) Due to (or as a consequence of):	
	ē	Sequentially list conditions, if any, leading to immediate b. Right Rib Fracture Due to (or as a consequence of):	
-	Examiner	C. County that initiated events resulting in feath) Last Due to (or as a consequence of):	
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876(ificate ug phys	Ž	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day	Year
Box 6876 death certificat he attending ph d for use as the	icia	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	
the dear	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause	o of dooth?
F. P.O ires that t signed by	ā	Heart and Lung Disease; Osteoporosis 1 ☐ Yes 2 ✔ No 3 ☐ Probably 4	
rds, require been si	Completed	24a. Was an 24b. Were autopsy find	
ecol re law te has ge 2 sł	ם	autopsy prior to completion performed? 1 ✓ Yes 2 No 1 ✓ Yes	
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n of ding P	Ë	27. Manner of Death 28a. Date of Injury (Month, Day,Year) 1 Natural 5 Pending 28a. Date of Injury (Month, Day,Year) (Month, Day,Year) 1 Yes 2 X No Complications of fall	
Division Division al or Attendi rs after death. al Director: /	Sati	2 K Accident Investigation fd 12-20-11 unknown 1 165 2 100 1	a Number City
Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifiely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route or Town, State) 820 Canton Av Baltimore, Md.	7e.
To the Hospital within 24 hours To the Funeral completely filled	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. One) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	s)
To with	Me	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day,	Year)
		Carol Hallan O.C.M.E. December 31, 2011	
	ļ	30. Name and address of person who completed cause of death (Item 23a)	
		Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32. egistrar's Signature	
Regist	232	JANO 9 2012 Lewe B. Jane	
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Unpend 23a, 27, per MAJ MC USA, g924 2-29-12 sm Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ CHESTER HENRY HAMMONDS JR 2011 DEC 7:18 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY BETHESDA 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, AUGUST 1 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 😾 M 2 🗆 F Days Min. Months Hours 18 577-11-2304 40 Yrs. WASHINGTON, DC Director 1971 Usual Residence of Decedent 10a State 10b. County 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 ☐ No BOWIE PRINCE GEORGE'S MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA ò ms 23a or 20716 15673 EASTHAVEN COURT ural", or items ? 12. Was Decedent Ever in U.S. Armed Forces?
1 t√2 Yes 2 □ No NAVY If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: BLACK"natural" Completed 3 Widowed 4 Divorced Specify: of Health and Mental Hygiene.
If item 27 is marked other than "nature or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) GOV T MEDICAL TECH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ESTELLE DORSEY မ CHESTER H. HAMMONDS SR. 19a. Informant's Name/Relationship (Type, Print)
ESTELLE HAMMONDS/MOTHER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7004 71st COURT CAPITOL HEIGHTS, MARYLAND 20743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State UNK Date permit. Page 1
Department of
Important: If it
any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ARLINGTON, VIRGINIA 4 Donation 5 Other (Specify) ARLINGTON CEMETERY 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service License 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Complications of Atherosclerotic Coronary Artery PENDING Disease Immediate Cause (Final †Trysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence on). attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy Day Year Pregnant at time of death been signed by the salould be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? this certificate has funeral director, page 2 autopsy performed? 1 ☐ Yes 2X No 2 🗆 No Yes the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certific 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 X Yes 2 ☐ No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 V Other (Specify) WRNMMC 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural injury Investigation 1 Yes 2 🗆 No Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined building, etc. (Specify) City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in revenience death and place. Medical 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Contifying Nurse Practioner: To the cent of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 or by one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 23260 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

LINDSEY D ROSCHEWSKI,

31. Date filed (Month, Day, Year,

JAN 0 9 2012

MD

32. Registrary Signal e

WRNMMC, BETHESDA, MD 20889 5600

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

aime Lynn Lidlow	State of Maryland / Department of 1-For State Certificate of Registrar		ygiene 20 i	1 4262
Physician/ Andical Examine	Decedent's Name (First, Middle,Last) Jaime Lynn Lidlow	II.	Date of Death Month December 28, 2011	3. Time of Death 0542 hrs
	4a. Facility Name (if not Institution, give street and number) Upper Chesapeake Medical Center	lb. City, Town, or Location of Death Bel Air	4c. County of Death Harford	
Funeral Director	$\begin{array}{c ccccccccccccccccccccccccccccccccccc$	If Under 1 Year If Under 24Hrs Months Days Hours Min.	Foreig	thplace (State or gn untry) NJ
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	on		10d. Inside City Limits
the Maryland a or 28a-f show titied at once. Director	MD Harford Bel Air 10e. Street and Number	10f. Zip Code	10g. Citizen of What Cou	1 Yes 2 X No
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fter death with ", or items 2. er must be n	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Yeer 1	es, specify Cuban, Mexican, Puerto Yes 2 No specify:		White
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Titem 27 is marked other than "matural", or items 23s or 28s-f short ranumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	t's Usual Occupation (Give kind of vost of working life, DO NOT use reti	red)	
nore, MD 21215-0036 ages 1 and 2 should be filed within 72 hou nt of Health and Mental Hygiene. It: If item 27 is marked other than "nat other traumatic event, the Medical Exa To Be Completed		18.Mother's Name	Food Serv	rice
2121 hould be fil and Mental F is marked tite event,			Rural Route Number, City or Town, State	, Zip Code)
ore, MD 2 jes 1 and 2 shou of Health and N H item 27 is in ther fraumatic	20a. Method of Disposition 20b. Place of Dispos	Sunrise Road, Be	elford, NJ 07718 Date 20c. Location - City or	Town, State
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum.	4 Donation 5 Other Specify: Bayview C.	rematory 12/	28/11 Baltimore abbard Funeral Home	
Physician		07 Wilkens Avenu	e, Baltimore, Mary	rland 21229 Approximate Interval
Medical Examiner	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) The failure. List only one cause on each line. a Heroin Intoxication Due to (or as a consequence of):			Between Onset and Death
- 0	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
Souted and transit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	T .	98355	
be execut iician and urial - tra	d. ☐ AMENDED 23a,27,28a-f,pe	er me,g923 1-13-	12 sm	
K 6876(n certificate ending phy: use as the b Ician/Me	past 12 months? 4 Pregnant at time of death 5 Ott	tal death 3 Ectopic pregna	23d. Date of delivery Month	y Day Year
p.O. Boy that the death ned by the att detached for by Physi	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco use contribute to	
ords, P.O. w requires that th us been signed by should be detach				topsy findings available
Division of Vital Records, tal or Attending Physician: The law requires rs after death. al Director: After this certificate has been signed in by the funeral director, page 2 should be artification: To Be Completed		00.00	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes	completion of cause of
F Vital Rec Physician: The I r this certificate all director, page To Be Con	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient		g Home 5 Residence 6 Other	.
ion of trending Physicath. tor: After the funeral	27. Manner of Death 1 Natural 2 Accident Pending Investigation 1 Accident 28a. Date of Injury (Month, Day, Year) 1 1 1 2 2 2 2 1 1 1 1 1 1 1 1 1 1 1 1	1 Ves 2 X No	28d. Describe how injury occurred unknown	
Division c Biospital or Attending 24 hours after death. Funeral Director: Af sety filled in by the fun all Certification	3 Suicide 6 X Could not be determined 28e. Place of Injury - At home, farm, stree (Specify) Friend S House		28f. Location (Street and Number or Ru or Town, State) 1319 Rom Bel Air, Md.	an Ridge Way
Division To the Hospital or Attention 24 hours after death within 24 hours after death To the Funeral Director: completely filled in by the Medical Certificati	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur one) 2 Medical Examiner: On the basis of examination and/or investigat and manner stated.	ion, in my opinion, death occurred a	at the time, date and place, and due to th	e cause(s)
	29b. Signature and title of certifier Dannel H. Herrich Land	29c, License number O.C.M.E.	29d. Date signed (Mo December 29, 20	
\varnothing	30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900	W. Baltimore Street, Balti	more, MD 21223	
State Registra				

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#30perDVR, G923, 1/972012, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 42624 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ De^{Month}31, LaRoy 2/011 Year William Laupp 40 a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CALUL KORL KEPUN ZC 2315 <u>Vern</u> 1 Year If Under 24 Hrs. 8. Date of Birth Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Ye 1 € M 2 □ F 34-01-Director 1560 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Yes 2 No aublic KE 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? ems 23a or Funeral 20616 454 items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Examiner Armed Forces Black, White, etc. ò þ 1 Never Married 2 Married 2 No Maryland 21215-0036 Yes 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates "natural", Specify: WHSTE 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ LLLSAM LMU CIUSTA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KULA L. 26/6 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service Licensee 23a, Dart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Artery Disease Physician oronary disease or condition seuce Medical resulting in death) Due to (or as a construence of): Examiner Atherosderotre tears. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death Year Yes 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Heart Disease Brain Meningiomas 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy Obstruc Diseuse Chronic Yes 2 N 25. Was case referred to medical examiner?

1 Yes 2 No filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation after death Director: / 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) e Funeral Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сотріетес Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 To the I within 2 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D17245 Hernes 2012 4. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19 Chesapeake Beach Road East Owings, MD 20736 Gerald Sterner 31. Date filed (Month, Day, Year)
JAN 0 9 2012 32. Registrar's Signature State Registrar

Physician /Medical Examiner

Funera

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Model Explainted must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	1	For State Registrar		Oldic 0	- warylan		Certifica	te of L	Death			Reg. N	2 (4	262	5
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ner	4	4a. Facility Name (If	not institution, g	ive street and nu	mber)				Location			40		y of Death			
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	4	5. Social Security Nu 216-60-0		Sex 1XDM 2□F	7. Age (In yrs. I	ast birtho	Months	r 1 Year Days	Hours	Min.	8. Date of Bir (Month, Da 11/29/	iy, Year	⁻⁾ 2	9. Birth Cou	place (S ntry)	MD	7
	-	Usual Residence of			10. 00	. Taum a	r Location								10d. Insi	ide City Limits	_
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ner	ŀ	11. Marital Status		12. Was Dec	edent Ever in U.	S.	13. Was Dece	dent of H	ispanic O	rigin? (Sp	ecify Yes or No Rican, etc.))-		ce - Ameri		an,	
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Be (1	17. Father's Name (First, Middle, Las	st)				İ	18. Moth	ner's Nam	e (First, Middle	, Maide	en Surna	me)			
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l.		19a. Informant's Na	me/Relationship	(Type. Print)		19b. N	Mailing Addres	s (Street	and Numl	ber or Rui	ral Route Numb	er, City	or Town	n, State, Z	ip Code))	
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			☐ Cremation 3 5 ☐ Other (Spec		State I	-	-			01/0	6/2012		BALT	IMOR	E, M	D	
	T	21. Signature of Fu			13512						L LEVIN						
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	+	23a. Part 1. Enter th	he disease, or co	mplications that	caused the deat	h. Do no									Appro	oximate val Between	
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Completed by Physician/M		Part II. Other signif	ficant conditions	s contributing to	leath but not res	ulting in t	he underlying	cause giv	en in Part	t I.	23e. Did	tobacc	o use co	ntribute to	the cau	se of death?	
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i i		2 Accident	investigat 6 ☐ Could no				M		Yes 2[No	201 111				/ B	do Mossofia a	_
ertifi		3 ☐ Suicide 4 ☐ Homicide	determine	ed 28e. Place	e of Injury - At h ling, etc. (Speci	ome, farr <i>fy)</i>	n, street, facto	ory, office			28f. Location City or To	(Street own, St	and Nur ate)	mber or Hi	ıraı Hou	te Number,	
Medical Certification: To	lear l	29a. Certifier (Check only one)	1 Certifying 2 Medical Ex	Physiclan: To the caminer: On the and ma	e best of my kno basis of examina nner stated.	owledge, ation and	death occurre /or investigati	ed at the to	ime, date opinion, d	and place leath occu	e, and due to thurred at the time	e caus e, date	e(s) and and plac	manner a	s stated.	cause(s)	
N	2	29b. Signature and	I title of certifier				2	9c. Licens	se numbe	r		29d.	Date sig	ned (Mont	h, Day,	Year)	
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		30. Name and add	ress of person wi	no completed cal	343	(1 (1 (1 (1)	ne/	Walk	in Di		Gaith	ersk	sort	M	>	2087	8
		31. Date filed (Mon	th Dav. Year)	32.4	registrar's Signa		,						ال -				_
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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Pauline Marshall Physician/ Month 27/2011 7:15a^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 715 Maryland Ave Essex Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 235-24-2754 89 **Director** 1 - M 2 XF 12/08/1923 OH 28a-f show 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore notified Essex 1 Yes 2 1 No r must be n 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 715 Maryland Ave 21221 USA with items death 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ral", or iten Examiner Black, White, etc by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. White 3 X Widowed 4 Divorced "natural" Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working th and Mental Hygiene.

27 is marked other than traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) State of MD Secretarty Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Wrabel Frances Strapec 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health of item 27 i Daughter 715 Maryland Ave Essex MD 21221 Janet Genovese other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date c If F cemetery, crematory or other place, 1 ☐ Burial 2 🏋 Cremation 3 🗀 Removal from State ō Department of Important: If any injury or once, 01/01/12 Glen Burnie MD Atlantic Crem 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simplicity Crem & Fun Ser Funeral Service ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Anterio Immediate Cause (Final Onset and Death Physician/ andiovascu disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of, attending physician and I for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🕱 No Month Day Year Pregnant at time of death signed by the at id be detached f 1 Yes 2 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy perform 2 No 1 Yes al or Attending Physician: s after death. I Director: After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 10 Other: 4 \(\sum_{\text{Nursing Home}}\) Nursing Home 5 \(\text{X}\) Residence 6 \(\sum_{\text{Other}}\) Other (Specify) 1 X Yes _ 2 🗌 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital within 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Configure Fractition or To the best of my knowledge death occurred at the time date and place and due to the cause(s) and manner stated. 29a. Certifier (Check 29c. License number 29d. Date signed (Month, Day, Year) December 29 2011 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) 6 TRIMBLE HILL CTLATHERVILLE, MD 21093 MD MILLTELLO

State Registrar 32. Registrar's Signatur

11-08558 Unk Unk

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2011 42627

		1- For State Registrar	Certificate of	f Death			Reg. No.			
Physicia		Decedent's Name (First, Middle,Last)	h Day Year	3. Time of Death						
ledical Exami		I ADDI MODRE	JR.			Month November	14, 2011	1625 hrs		
		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of Deat	th		
		1325 N. Carey Street		Baltimore			N/	A		
			(In yrs. last birthday)	If Under 1 Yea	r If Under 24Hrs	8. Date of Bir	h(MM/DD/YYYY) 9. Bi	irthplace (State or		
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Director	L	215-86-33/3 12M 20F	39 Yr	S.)4P10	20,192	ountry)		
	Ĺ	Usual Residence of Decedent						10d, Inside City Limits		
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Maryland 28a-f show d at once.	융	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What Co	untry?		
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hours after death with the Maryland 'natural', or items 23a or 28a-f sho Examiner must be notified at once		11 Marital Status 12 Was Decedent E	Svor in II S I 13 W	as Decedent of Hi	spanic Origin? (Sp	ecify Yes or No	- 14. Race - Ame	erican Indian, Black,		
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or it	Funeral	1 Yes 2	X No	Yes 2 X No	onocity:		Specific /	LACK		
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	à	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1-1-1 1 160 December		ation (Give kind of	work done	16b. Kind of Business	, —		
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2121 suld be fil Mental I marked	Be	LARRY MOORE,	JR.		aloi	ela	MOOR			
	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Stre	et and Number or I		nber, City or Town, Sta			
MD 12 sho th and a 27 is		LELORIA MOORE / MOT	nex 35/	/ Kub.	ZN AVE		cro, MD	2/4/5		
_ 4 7 7 8 2		20a. Method of Disposition	20b. Place of Dispo crematory or o		emetery,	Date	20c. Location - City of	or Town, State		
Saltimore bermit. Pages 1 a Department of He important: If it		1 Burial 2 Cremation 3 Removal from Sta		1 Jour	april 11	2/2012	Inlande	THE, MD		
timen trans		4 Donation 5 Other Specify: 21. ure of Puneral Servi censee	1 .2/1/1	Name and Addres	s Facility	1000		MARTIE		
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Division of Vital Records, P.O. ral or Attending Physician: The law requires that the start death. **All Director** After this certificate has been signed by led in by the funeral director, page 2 should be detach	Completed by					24a. Was	an I 24h Were	autopsy findings available		
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ivisior or Attendather death Director:	<u>≗</u>	3 Suicide 6 X Could not be 28e. Place of In	jury - At home, farm, str	reet, factory, office 1 of vaca	nt.	or Town,	State) 1325 N. (Carey St.		
pite Durs a Caral Illed	Certification:	4 Homicide determined (Specify) bu	11ding			Baltimo	re,MD.			
Hos 24 hc Fun			y knowledge, death occ	curred at the time,	date and place, an	d due to the cau	ise(s) and manner as st	tated.		
Division of Vital Records, P.O. Box 68. To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as:	Medical	one) 2 Medical Examiner: On the basis of examiner and manner stated.	mination and/or investig			at the time, date				
E3E8	¥	29b. Signature and title of certifier		29c. Lice	nse number		29d. Date signed (#			
		In al Smill all max		0.0	C.M.E.		November 15,	2011		
7		30. Name and address of person who completed cause of cause of	leath (Item 23a)							
W	8	Pamela E. Southall, MD Assistant Medi		00 W. Baltimo	ore Street, Bal	timore, MD 2	21223			
<u></u>										
Penis		IAN 0 9 2012	r's Signature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 42628 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December Physician/ 2011 4:50 P M Maloney Elwood George Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Carroll Hospice Dove House Westminster 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number . Age (In yrs. last birthday) **Funeral** 1 🖾 M 2 🗆 F Months Days Min. California Hours Director 1932 564-36-5489 79 July Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No New Windsor Carroll Maryland 10f. Zip Code 10g, Citizen of What Country's 10e. Street and Number Funeral U.S.A. 21776 1914 Old New Windsor Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates. 1950-52 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event the Man College (1-4 or 5+) Elementary/Seconday (0-12) master electrician/engineer newspaper 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Ethel Irene Coe George E. Maloney Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2736 Littlestown Pike Westminster, MD 21158 John P. Maloney/ son Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Druid Ridge Cemetery 1/5/2012 Pikesville, MD 4 Donation 5 Other (Specify) Signal of Foreral Service Licenses 22. Name and Address of Facility Hartzler Funeral Home 310 Church St. New Windsor, MD 21776 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Floysonian/ disease or condition resulting in death)) Medical Examine Sequentially list conditions Examine Due to (or as a consequence of) cause (Disease or linjury been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death Yes 2 No g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed 1 Yes 2 No After this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Hospital Other: 4 Nursing Home 5 Residence 6 Nother (Specify) hospice ျှ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Dear 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 5 Pending injury s after death. 2 🗌 No Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral C Medical Certifying Physician: To the best of my 'knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated сотрыете (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 3 only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif address of person who completed cause of

Registrar

32. Regi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ARECL Medical County of Death 4a. Facility Name (if not institution, give street and number Town, or Location of Death **Examiner** er. Birthplace (State or Foreign Country) . Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** Hours Min (Month Director 3 Usual Re or 28a-f show 10a. State with the Maryland injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MA 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a USA 81220 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. or g 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates "natural", Specify: 3 Divorced Completed te 15. Decedent's Education (Specify only highest grade completed) 18a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Secondary (0-12) 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Page 1 and 2 should ment of Health and Me Informant's Name/Relationship (Type, Print) or Rura Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) inidalK Home, FUNERAL any 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): ending physician a r use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ____ Month Day Year Pregnant at time of death been signed by the a should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, 1 Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy perform After this certificate 2 No 1 Yes Yes Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 1 Natural 28c. Injury at 28d Describe how injury occurred 5 Pending work? 1 🔲 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title

Registrar

DHMH 17 Rev 06-2011

H

State

31. Date filed (Month, Day, Year)

Print)

rson who completed cause of death (Item 23a) (Type and the complete of the com

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Kimberly Pinkcett	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 20 426
Physician/ Modical Examiner	1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death
	4a. Facility Name (if not institution, give street and number) Holy Cross Hospital 4b. City, Town, or Location of Death Silver Spring Montgomery
Funeral Director	5. Social Security Number 0. Sex 1 Age (In yrs. last birthday) 1 Months Days Hours Min. 1 2/21/1973 1 2/21/1973 1 2/21/1973 1 2/21/1973 1 2/21/1973
aryland 8a-f show any atouce. ector	Usual Residence of Decedent 10a. State
ith the M 23a or 2 notified al Dire	13921 Castle Blvd Apt 13 20904 USA
s after death with i	Specify.
2 hour "natu	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Syrs 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker Homemaker
21215-0036 Juld be filed within 7 Mental Hygiene arked other than c event, the Medica TO BE Complé	17. Father's Name (First, Middle, Last) William Hignutt 18. Mother's Name (First, Middle, Maiden Surname) Ida Georgius
MD 21215 d 2 should be file thand Membal H nn 27 is marked I numatic event, is	19a. Informant's Name/Relationship (Type, Print)19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)Ida Wheat Mother17 Hanover RD Apt 2 Reisterstown MD 21136
Baltimore, MI pemit. Pages I and 2 a Department of Health a Important: Witem 27 injury or other traum	20a. Method of Disposition 1
Baltil permit. J Departm Importa	21. Signature of Funeral Service Licenseer 22. Name and Address of Facility Simplicity Crem & Fun Service Licenseer Thomas Allen PA 7090 Ridge Rd Hanover MD
Physician Wedical £xaminer	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive Cardiovascular Disease Approximate Interval Between Onset and Death
-	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
D, be executed sician and nurial - transit edical Examiner	course. Enter Underlying Course (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
O, e be executed ysician and burial - transit	d. X UNPENDED AMENDED 23a,pt.II,27,per me,g925 3-1-12 sm
ox 6876(eath certificate at the triang phy for use as the triangle)	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1
, P.O. B res that the d signed by the be detached d by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted in the funeral director, page 2 should be detacted in the funeral director, page 2 should be detacted in the funeral director.	24a. Was an autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
F Vital Representations of the physician: The predictor of the ral director, page To Be Cor	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other:
ion of ttending Ph leath. tor: After t the funeral	27. Manner of Death 1
Division o spital or Attending ours after death. neral Director: Afte filled in by the fune Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the Medical Certificating	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
Ž	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) December 29, 2011
6	30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
State Registrar	

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42631 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ RAAB a GNOMPA 23:13 M DE CEMBER 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Washington Adventist Hospital Montgomery Takoma Park 7. Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min Country) 1 □XM 2 □ F 0476377943 PA 215-42-7026 68 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director WV Berkeley Springs Morgan 1 ☐ Yes 2X No 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 249 Meadowlark Lane 25411 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked with any or with the contract of the co "natural", or i Completed by 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give 1 ☐ Yes 💥 No Specify: Specify: White 3 Widowed 4 X Divorced Year or Dates 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Dept of Defense Engineer 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Florence Patrick Raymond M. Raab 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son 103 Mason Place Boonsboro MD 21713 Raymond T. Raab 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crem 20a, Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 01/03/12 Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simplicity Crem & Fun Serv 21. Signature of Euperal Service Licenses ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 117 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence or). Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year Pregnant at time of death 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 Yes 2 No Yes 2 Be B 25. Was case referred to medica 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) te: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Certifica 1 🔲 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4000 MINONA Winer State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM# 20b perFH, G923, 1/9/2012, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Dec 30, Physician/ 9:44 Meredith Louise Routson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Westminster Dove House If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month. Day) 9. Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** 7. Age (In vrs. last birthday) Months Days nth, Day, Hours 1 M 2 X F Maryland Yrs Director Oct 1945 218-44-3055 66 Usual Residence of Decedent 28a-f shov 10a State 10h. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director Hampstead Carroll 1 Yes 2 X No MD 10f. Zip Code 9 10e. Street and Number 10a. Citizen of What Country? ms 23a or must be n Funeral U.S.A. 21074 4537 Whetstone Court items death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, r than "natural", or iter the Medical Examiner Black, White, etc. þ 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry oe filed wro.. خا Hygiene. خا **r than** "r (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other tware. Own Home Housewife 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Clara Jarrett Earl Miller, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hampstead, Maryland 4537 Whetstone Court Blaine W. Routson Husband 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1/5/2012 cemetery, crematory or other place) 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Hampstead, Maryland 4 ☐ Donation 5 ☐ Qther (Specify) 5/12Carroll Cremation Ser f Funeral Serv 22. Name and Address of Facility 11824 Reisterstown Road Wayne Osterling ELINE FUNERAL HOME Reisterstown, MD J. 23a. Part 1. Enter the visease, or complications that caused the death. Do not enter the mode of dying, such as cardia, or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to lor as a consuluence of Examir burial-trans and Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year 5 Other (specify) Pregnant at time of death signed by the aid be detached to detached Unknown Unknov P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Completed neec 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Hospital or Attending Physician: The law this certificate has ral director, page 2 : autopsy performed? Yes 2 No 25. Was case referred to medical Division of Vital funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Hospital 1 ☐ Yes 2 ☑ No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 5 Pending iniury work? 1 ☐ Yes 2 ☐ No death Accident Investigation 24 hours after deat Funeral Director: 6 Could not be 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier peteld (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 the only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number ည 10 who completed JAN 0 9 2012

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

11-09427

Nelson Ray Schlothouer

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	F	- For State Certificate of Death	,,,,,	Reg.	No.			
Physiciar	1/	1. Decedent's Name (First, Middle,Last)		e of Death oth D cember 1	ay Year	3. Time of Death 1147 hrs		
ledical Examin		Nelson Ray Schlothouer 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of		cember 1	5, 2011 4c. County of Deat			
	ı	8200 Pulaski Highway #17 Rosedale	Death		Baltimore Co			
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under	1 2 2	,	MM/DD/YYYY) 9. Bi			
Director		218-32-7153 1XM 2F 75 Yrs. Months Days Hours	Min. Mag	y 4 , 1	.936 c	buntry)Maryland		
any	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits		
* .	1	MD Baltimore Rosedale				1 Yes 2 X No		
// Aaryland 28a-f show	Ulrector	10e Street and Number 10f. Zip Code		10g.	Citizen of What Cou	intry?		
the N		8200 Pulaski Hwy #17 21237		USA				
th with		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origi 1 Never Married 2 Married Armed Forces? 13. Was Decedent of Hispanic Origi 14. Francisco Procestal Status See See See See See See See See See Se			14. Race - Amer White, etc.	rican Indian, Black,		
er dea		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:			Specify: whi	ite		
urs afi	핡	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give k		ne 1	6b. Kind of Business			
72 ho	<u>ĕ</u>	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT u	use retired)			1		
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and 2 shou (ealth and N tem 27 is n traumatic	L	Donna Settar - daughter 3456 Sollers Poi		Dund	alk, Mary	land 21222		
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Baltimore, ocenit. Pages la coemit. Pages la coepartment of Her (mportant: If ite injury or other tr	L	4 Donation 5 X Other Specify in State		A 5 -	D 1			
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Physician	+	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca				Approximate Interval Between Onset and		
/Medical Examiner		fallure. List only one cause on each line. Immediate Cause (Final disease a Atherosclerotic Cardiovascular Dis	sease			Death		
ZXXIIIIIOI		or condition resulting in death) Due to (or as a consequence of):						
	<u></u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):						
	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):							
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8760, ifficate be ng physic as the bur		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic	pregnancy		23d. Date of deliver Month	" y Day Year		
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the described by the sched for	Ë	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Par	rt i. 2	3e. Did toba	acco use contribute to	the cause of death?		
ires that the signed by t	6			1 🗸 Yes	2 No 3 Pro	bably 4 Unknown		
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Reco				performe ✓ Yes 2	ed? death?	_		
tal Rection: The certificate ector, page	8 8	25. Was case referred to medical 26. Place of Death ((Check only on	ie)				
Viti hysici Il direc	<u>∘</u> L	Tes 2 No	Nursing Hom		esidence 6 🗸 Othe	er: Scene		
Division of Vital Records, tal or Attending Physician: The law requir ra after death. al Director: After this certificate has been sin the fineral director, page 2 should been in the fineral director, page 2 should be the fineral director, page 2 should be the fineral director, page 2 should be the fineral director, page 2 should be the fineral director, page 2 should be the fineral director, page 2 should be the fineral director, page 2 should be the fineral director.	;;	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 X Natural 5 Pending 1 Yes 2	- 4	escribe hov	w injury occurred			
Sion Attend r death ector: by the	<u> </u>	2 Accident Investigation 28e Place of loury - At home farm street factory office building etc.		ocation (Stre	eet and Number or R	ural Route Number, City		
Divi	Certification:	Suicide 6 Could not be determined (Specify)		r Town, Stat				
		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check page)	ice, and due to	the cause(s) and manner as sta	ted.		
To the within To the compl-	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occard manner stated. 29b. Signature and title of certifier 29c. License number	curred at the ti		d place, and due to to 29d. Date signed (Mo			
	2	29b. Signature and title of certifier 29c. License number O.C.M.E.			December 16, 2			
	-	30. Name and A mess of person who completed cause of death (Item 23a)						
	ł	Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street,	, Baltimore	, MD 212	223			
Sta Registr	te	31. Date filed (Month, Day, Year) 32. Fegistrar's Signature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. and #10b Per FH G924 2/08/2012 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 1844 P Physician/ SAUNDORS Month 2ŏ ESTELLE VIRGINIA DE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CARROLL HOME CARE/CARROLL HOSPICE WESTMINSTER CARROLL 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖊 F Days 230-38-6140 90 1921 VIRGINIA Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County Carroll 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD. MT. AIR 1 Z Yes 2 No 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral BLUD. 705 RIDGEVILLE USA 21771 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BUNCK 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72., h and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE FAMILIES Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) RUCKER Ltt JANIE TIMBERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau MARVINE. SAUNDERS SON) 4205 FLAM ST. FORT WASHINGTON MD. 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State RESTHAVEN MEM, 6D, JAN 5, 2012 FREDERICK 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility GARY L. ROLLINS FUN. HOME Kollin my 2. 110 WEST SOUTH ST FREDERICK, MO 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician! disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): **Hospital or Attending Physician:** The law requires that the death certificate be executed anding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: Live Birth 2 Fetal death yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗆 Yes 🖭 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: Other (Spe ည 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death 28c. Injury at work? 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tyes 2 🗀 No Investigation Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) filled in by 4 Homicide determined e Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier (Month, Day, Year) person who completed cause of death (Item 28a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Date filed (Month, Day, Year)

JAN 0 9 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23a per dr., g923, 01/09/2012dhb trar Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Anna Catherine Sealover 2011 8:30a M Dec. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Belair 2209 Kempton Park Circle 8. Date of Birth (Month, Day, Year)
Aug. 14, 1921 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours MAryland 1 🗆 M 2 🗚 90 Director or 28a-f show 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho aţ 10a. State 10b. County Director Rosedale must be notified 1 🗌 Yes 2 🔀 No Baltimore 10f. Zip Code 21237 10e. Street and Number 8625 Philadelphia 10g. Citizen of What Country? USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates White Completed 3 Widowed 4 Divorced any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Beautician Hairdresser 8th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Richard A. Schuman Anna 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 2209 Kempton Park Circle Bel**å**ir MD 19a. Informant's Name/Relationship (Type, Print) Richard Sealover 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 🛭 Burial 2 🗆 Cremation 3 🗀 Removal from State Gardens of Faith 12/28/11 Rossville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD . Signature of Funeral Service Licenses Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line thrive Ons, t and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Atherosclerosis Unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Dav Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant a g 🗌 Unknown P.0. signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law cate has I autopsy performed 1 🗌 Yes 2 🗆 No 1 Yes 2 No certificate within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence & Other (Specify) Son s 2 No ပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at work?
1 Yes 2 No iniury 1 Matural 5 Pending Accident
Suicide Investigation 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12.27.2011 ST Eleten MOZAZI 31. Date filed (M State Registrar

Please Type of Print in Black Indelible Ind Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2011 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ LEROY SHEPPARD DECEMBER 2012 2:23 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE FT. WASHINGTON FT. WASHINGTON HOSPITAL 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min , *Day*, 1 🕱 M 2 □ F JÜNE 1933 FLORIDA Director 264-48-0434 78 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland at Director notified 1 X Yes 2 ☐ No MD PRINCE GEORGE'S OXON HILL 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or ed other than "natural", or items 23a o event, the Medical Examiner must be Funeral 20745 USA 4600 CALAIS STREET 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 □XYes 2 □ AoIRFORCE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 XYes If Yes, Give Maryland 21215-0036 BLACK 1 ☐ Yes 2X☐ No Specify: Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) should be filed within CONSTRUCTION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ SHERMAN SHEPPARD MARIA LEE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau SHEPPARD/EX-WIFE CALAIS STREET OXON HILL MARYLAND 20745 MATTIE R. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State MD VETERANS CEMETERY 1/17/2012 CHELTENHAM, MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. of Funeral Service Licensee 21. Signature Reeks 7474 LANDOVER RD HYATTSVILLE, MARYLAND 20785 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shork, or heart tailure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

ALZHEIMER'S DISEASE

Due to (or as a consequence of): Approximate Interval Between Onset and Death Physician/ Medical Examiner DEMENTIA Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) -trar that initiated events resulting in death) Last Due to (or as a consequence of) ending physician a use as the burial-Physician/Medical P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy atten for u in the past 12 months? Day Month Year Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I by 1 Yes 2 No 3 Probably 4 Unknown Records, Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of cate has page 2 s autopsy performed il or Attending Physician: The safter death. Director: After this certificate 1 ☐ Yes 2 ☐ No Yes 2 X No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Inpatient 2 K ER/Outpatient 3 ☐ DOA 1 🗌 Yes 2 **X**No မ funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Certificate: injury work? 1 X Natural 5 Pending 2 🗌 No Accident Investigation filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Cortifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check within 24 3 E only pe 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) JANUARY 3, 2012 D24535 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAXMI BERWA MD 7700 OLD BRANCH AVENUE C101 CLINTON, MARYLAND 20785 31. Date filed (Month, Day, Year, 32. Registrar's Signature State fale Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 25 per me, g923,01/12/2012dhb
State of Maryland / Department of Health and Mental Hygiene
realte Amend Item 23a Per dr.,g923,01/09/2012dhb 30
Reg. No.

Reg. No. 42637 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Yea Physician/ 55P M 28 2011 irginia Decembe Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** iti The Johns Hokins
5. Social Security Number 6. Sex Saltimore If Under 24 Hrs. 9. Birthplace (State or Foreign If Under 1 Year 8. Date of Birth Age (In yrs. last birthday) **Funeral** Months Days Hours Min. (Month, Day, Year) Director 1 🗆 M 2 🖼 F 56 220-64-8941 03-25-1955 VA Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location at Director notified 28a-f 1X Yes 2 □ No COLUMBIA MD HOWARD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number č must be by Funeral 23a 21044 USA 5161 COLUMBIA DRIVE "natural", or items permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 🎇 No If Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ TECHNICAL TRAINER DEPT. OF DEFENSE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 JAMES EDWARD SIMPSON ANN ELIZABETH THOMPSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DONALD WILSON/HUSBAND 5161 COLUMBIA DR., COLUMBIA, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Denation 5 Other (Specify) 12/30/11 BALTIMORE, MD CREMATYORY of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC Signatur 1 1701 LAURENS STREET, BALTIMORE, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Physician/ Due to (or as a consequence of): disease or condition Medical resulting in death) Examiner Intracranial Aneurysm Sequentially list conditions, Examine Due to for se a consequence of if any, leading to immedicause. Enter Underlying APPROVED BY MEDICAL EXAMINER Cause (Disease or injury that initiated events as the burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical CERTIFICATION certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IE EEMALE: nse 23d. Date of delivery 23b. Was decedent pregnant for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Dav ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No the Hospital o Attending Pt ysician: The 2 No 1 \sum Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 X Yes Hospital: Other: မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work?
1 Yes 2 No ✓ Natural 5 Pending Accident Investigation Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Homicide 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 2 RES-200 28 December 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) The Johns Hopkins Hospital, 600 North Wolfe St., Baltimore, MD Badzik. 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physic		Decedent's Name (First, Middle,Last) Decedent's Name (First, Middle,Last) Day Year														3. Time of Death
dical Exam	iner	Michael	. Jay	Tarquin	io							Decemb	er 27, 2	011		1904 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of De Anne Arund														
		3600 Laure	I Fort Mea	ide Road				Laurel								
Funeral		5. Social Security	Number	6. Sex	7. Age (In yi	rs. last bir	thday)	If Under Months		If Under:	24Hrs. Min.	8. Date of E	Birth(MM/D	D/YYYY)	9. BirtlForeign	hplace (State or
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or it	F	1 X Never Marri		1 Yes	2 👿 N	0			_					********		-1
s afte ral",	þ	3 Widowed		vorced If Yes, Give Y		n 140-		Yes 2	Λ		1.6			Specify:		White
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215-0036 be filed within 7 ntal Hygiene. ked other than ent, the Medica	Be C			Tarquini	0					usan		rker	,			
21; Men Men marl	To E	19a. Informant's Na				19	b. Mailing /	Address				ral Route No	umber, City	y or Town	, State,	Zip Code)
MD d 2 sho d 2 sho lth and a 27 is	-	Tracey Ta	rquini	o / Aunt		1	29 Mo	ntgo	mery	Ave.	., в	ala Cy	ynwyd	, PA	190	004
nore, MD 21215-0036 sges I and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. 11: If item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Dis	position			b. Place	of Dispositi	ion (Name				Date				Town, State
MOFE, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygene. Int: If item 27 is marked other than "natural", or items 23a or 28a-fabor other traumatic event, the Medical Examiner must be notified at once			71	n 3 Removal			•	'	T		n1 /n	6/2019	Do 1			M11
		21. Signature of Fu	Other S	pecify: Licensee Δ1 ₃₇	son K T	av1o	22. Na	me and A	y III	Facility (JI/U	o/ZUL	Soci	L LIIIO	of 1	Maryland Maryland
Balti permit. Departn Import injury		Agou	im	Zon'	SOII K I	.ay10	299) Fre	deri	ck Ro	nad.	Ralt:	imore	Ma	rv1:	and 21228
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart											t	Approximate Interval Between Onset and		
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a Combined Alcohol, Tramadol, Hydrocodone and Nordiazepam Intoxication										Death				
ZXaimmer		or condition resulti			a consequenc		•				<u> </u>		11			
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Sox 687 leath certifing e attending for use as t	ian	past 12 months		I LIVE	pnant at time of	f death	Feta			Ectopic p	regnand	У	\	Month	D	ay Year
Box 68 ne death certifi the attending	Physician	1 Yes 2	No 9 Uni	cours =	nown		Otne	er (Specif	y)							
O. In the last the tached		Part II. Other signi	ificant condit	tions contributing	to death but no	ot resultin	g in the un	derlying c	ause give	en in Part	I.	23e. Did	tobacco us	se contrib	ute to ti	he cause of death?
ires that the signed by	d by											1 _ Y	es 2 🗸	No 3	Proba	ably 4 Unknown
cords, law requir has been s	Completed											24a. Wa				opsy findings available
e law e has ge 2 s	Ε												ormed?	de	ath?	ompletion of cause of
tal Rec cian: The certificate ector, page		25. Was case refer	red to medica	1				26	Place of	Death (C	heck on	-	2 No	1 1	✓ Yes	2 No
Division of Vital Records, rate of Attending Physicians: The law requirers after death. 11 Director: After this certificate has been sited in by the functal director, page 2 should be an about the functal director, page 2 should be a second by the functal director, page 2 should be a second by the functal director, page 2 should be a second by the functal director, page 2 should be a second by the functal director.	o Be	examiner?		Hospital: 1	Inpatient 2	ER/O	utpatient		101	hor 🗔		Home 5	Residen	ce 6 ✓	Other:	Scene
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ion c tending eath. tor: Af the fun	tior	1 Natural	5 Pend	uning D 0	th, Day, Yeer) D: 7, 2011		JND: 4 hrs		1 Yes	2 🗸 N	。 lΩ	nknown				
r Att	fica	2 Accident 3 Suicide			ace of Injury - A			factory, c	office buil	ding, etc.	2			d Number	or Rur	al Route Number, City
Divisor At pital or At ours after d ceral Direct filled in by	Certification	4 Homicide			/) Multi-Fa	mily Ap	t.				36	or Town, 300 Laurel	State) Fort Mea	de Road	l, Laure	el, MD
Hosp 24 hor Fune tely fi		29a. Certifier 1	Certifying P	hysician: To the be	•			ed at the ti	me, date	and place	e, and d	ue to the cau	use(s) and	manner a	s state	d.
Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	edical	one) 2 🗸		miner:On the basis	s of examinatio											
FSFS	Me	29b. Signature and		er				29c. l	License n	umber			29d. Da	ate signed	(Mon	th, Day, Year)
	O.C.M.E. December 28, 2011									11						
0 /		30, Name and addr	ess of person	who completed ca	use of death (I	tem 23a)										
カン		Ling Li, MD	Assista	int Medical Exa			altimore	Street,	, Baltim	ore, Mi	D 212	23				
S	tate	31. Date filed (Mon	th, Day, Year)	32. F	Registrar's Sign	nature										

DHMH 17 Rev 1/2001

ORIGINAL

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Theodore Leslie Ta	Sker 1- For State	State	of Maryla			Health and	Mental H	ygiene	ر ا	n I	1 4263
Physician/	Registrar	_ ne (First, Middle,Las	st)	Cer	tificate of	Death	-	2. Date of Dea		0 1	3. Time of Death
Medical Examiner	Theodo	re Leslie	Tasker	ı, Jr.					г 22, 2011		2310 hrs
	4a. Facility Name	(if not institution, giverge's Hospital	e street and nu	mber)	4	b. City, Town, or L Cheverly	ocation of Death		4c. County Prince C		
Funeral	5. Social Security	<u> </u>		7. Age (In yrs. la	ast birthday)	If Under 1 Year	If Under 24Hrs				hplace (State or
Director	579-80-8		M 2_F	46	Yrs	Months Days	Hours Min.	15/16	/1965	Foreig Cou	n untry) DC
	Usual Residence	of Decedent						_ 			10d. inside City Limits
ow any	10a. State	10b. County			Suitlar						1 X Yes 2 No
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5-0036 ed within 72 hour lygiene. other than "natt the Medical Exa	Elementary/Sec	condary (0-12)	College (1	-4 or 5+)		ident	DO NOT use real	ieu)	Stu	ıdent	ī
5-0036 iled within 77 Hygiene. 4 other than the Medical		(First, Middle, Last)	_			8.Mother's Name	(First, Middle,			
215 be file onal Hy rked o	 Theodore	Leslie T	asker,	Sr.			Audrey L	orrain	e Spence	er	
h MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f abtranmatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director		ame/Relationship (1				Address (Street				n, State	Zip Code)
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Division o pital or Attending nous after death. Tellied in by the function:	2 Accident 3 Suicide	Investigat	28e. Plac	e of Injury - At he		et, factory, office bu		28f. Location (or Town,	Street and Numb	er or Ru	ral Route Number City ion Ave. N.E
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To the Ho within 24 To the Fu complete!	(Check only one) 2	7 ·	er:On the basis	of examination a	nd/or investigation	red at the time, dat tion, in my opinion,	death occurred	at the time, date	and place, and	due to th	e cause(s)
e i i i i i i i i i i i i i i i i i i i			and manner s	tateu.		29c. License	number				nth, Day, Year)
		mari				O.C.N	И.Е. 		December	23, 20)11
8	30. Name and add	dress of person who Assistant N				re Street, Balti	more, MD 21	1223			
State				gistrar's Signatu		-					
Registra	J.,	NO 9 201	2	wa d	par	le l					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 12 Month Physician/ Day 30 201°1 KATHERINE ELIZABETH TAYLOR 1:20 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Genesis Healthcare Severna Park Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Hours 04 30 1928 216 24 2961 83 Director Usual Residence of Decedent 3a or 28a-f show t be notified at 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits MD 1 Yes 2 X No Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 7652 Water Oak Point Road 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or itel þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed 3.X Widowed 4 Divorced White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important: If item 27 is marked c any injury or other traumatic eve once. ည John E. Zentgraf Mary E. Reeb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7652 Water Oak Point Rd Pasadena, MD 21122 Michael Roberge - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Loudon Park Cem 1/6/2012 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility GJ Gonce Funeral Home Signature of Funeral Service Licensee 169 Riviera Drive Pasadena, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of; Exam Cause (Disease or iinjury Dementia attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the bur completed filled in by the funeral director, page 2 should be detached for use as the bur or page 1. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) 1 Yes 2 Dunknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🔀 No Other: 4 X Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending 1 X Natural injury Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Z Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar 8601 Veterans Highway

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Deborah Badro
31. Date filed (Month, Day, Year)

JAN 0 9 201

12/30/2011

Millersville, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Maryland / Department of Health and Men 1 - State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 11:50 PM December 2011 Medical Frank Wagenhoffer 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Halethorpe 5633 Oakland RD 9. Birthplace (State or Foreign ocial Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Davs Hours (Month, Day, Year) 217-38-4961 **Director** 1 🕅 M 2 🗆 F 75 Yrs. March 19, 1936 Hungary Usual Residence of Deceder show or 28a-f shov notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore Halethorpe 10e, Street and Number 10f. Zip Code 9 10g. Citizen of What Country? ed other than "natural", or items 23a o event, the Medical Examiner must be Funeral 5633 Oakland Road 21227 USA 1 and 2 should be filed within 72 hours after death of Health and Mental Hygiene.
item 27 is marked other than "natural" notional Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: Completed 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Industrial Electrician Electrical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joszef Wagenhoffer Elizabeth Zimmerman injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Barbara A. Hedrick - Daughter</u> 5633 Oakland Road, Halethorpe, Maryland 21227 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. Page 1 cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory, Inc 12/31/11 Glen Burnie, Maryland Gary L. Kaufman F.H. @ MMP 21. Signature of Funeral Service Lice. 22. Name and Address of Facility lblo 7250 Washington Blvd., Elkridge, Maryland 21075 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, list only one cause on each line. 23a. Part 1. Enter the disease shock, or heart failure. L Immediate Cause (Firal Onset and Death Physician/ 4 thero scheootic Cardiovasie disease or condition years Medical Examiner resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami for use as the burial-transi Due to (or as a consequence of): nding physician Physician/Medical death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law r 24 hours after death.
 Funeral Director: After this certificate has b cate has I; autopsy performed 2 No Yes 2 X No 1 Yes completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 KResidence 6 Other (Specify) Hospital 1 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2011 132158 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DV 516 N. Kolling Ste 108 Catonsville, My 21228 MD Kond 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 9 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 12/10/2011 Physician/ 4:55a M Minnie Ashford Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Cherry Lane Nursing Center Laurel 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Age (In yrs. last birthday) 89 yrs. Social Security Number **Funeral** (Month, Day, Sept. 3, Hours Months North Carolina **Director** 239-58-6186 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10c. City, Town or Location with the Maryland 10a. State "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director Adelphi Prince Georges M D 1 X Yes 2 No 10f. Zip Code 20783 10g. Citizen of What Country? 10e. Street and Number 20th Funeral 8424 Avenue United States death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ò 1 Never Married 2 Married African Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify: Specify: If Yes, Give Completed 3 Widowed 4 Divorced A merican Year or Dates. the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic (Specify only highest grade completed) College (1-4 or 5+) **4yrs** Elementary/Seconday (0-12) Education Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lillie Faison George 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Avenue, Adelphi, Maryland 20783 8424 20th Brenda R. Swanson / niece Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition
1 ♣ Burial 2 ☐ Cremation 3 ♣ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 12/22/2011 Clinton, NC 4 Donation 5 Other (Specify) Sandhill Cemetery 22. Name and Address of Facility McGuire Funeral Service, Inc.
7400 Georgia Avenue, NW, Washington DC 20012 NO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 2-3 wks Immediate Cause (Final Physician/ Septicemia disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** 2-3 wks Pneum onia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of): burial physician sthe burial Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo Day Month Year 5 Other (specify) Pregnant at time of death been signed by the should be detached g Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Brain Metastases 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? Coronary Artery Disease 24a. Was an autopsy has page 2 performed Atrial Fibrillation 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) Hospital: 2**XX**No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ပ within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: work? 1 X Natural 5 Pending 2 🗌 No Investigation ☐ Accident ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [only o 29b. Signatue and title of certifier TTENDING 29d. Date signed (Month, Day, Year) 29c. License number

Registrar

DHMH 17 Rev 7/2009

State

PHYSICIAN

82. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Baako, M.D.

DEC 1 6 2011

31. Date filed (Month, Day, Year,

Doo57216

3450 Ft. Meade Road, Laurel, MD suite#209

December 14, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 2011 Virginia Armstead 19:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Days Hours 06-14-1932 Country) Virginia Months Min. Director 578-52-3115 79 Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at with the Maryland Director 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 No Prince George's Hvattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4922 LaSalle Road 20782 United States hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 🛮 Never Married 2 🗆 Married þ Maryland 21215-0036 1 Yes 2 No Specify If Yes Give Specify: 3 Widowed 4 Divorced Completed Year or Dates Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) within 72 Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Private Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 1 and 2 should be fill of Health and Mental item 27 is marked ည Unknown Silvia Armstead 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Cunningham/ Cousin K St. S.E. Washington, DC 20003 injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite 1 🖰 Burial 2 🗆 Cremation 3 🗆 Removal from State Fort Lincoln Cemetery 12-29-2011 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility Fort Lincoln Funeral Home any Bladensburg Rd Brentwood Md 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine or Attending Physician: The law requires that the death certificate be executed as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and attending physician Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☒ No for Month Day Year Pregnant at time of death detached the 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Records, 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 1 ☐ Yes 2 ₺ No Division of Vital director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🖾 No Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) ည Inpatient 2 ER/Outpatient 3 DOA this filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work? Investigation
6 Could not be 1 Yes 2 No 24 hours after death. Funeral Director: A Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, DEC 2 7

Day, Year) 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42644 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 Joseph R. Amato 7:30 December Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Brookeville Marian Assisted Living 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 3irtny. Country) NY (Month, Day, Year) b. 3, 1920 1 X M 2 □ F Months Hours 91 Director 121-10-5204 Feb. Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Yes 2 No MD Montgomery Brookeville 5 10e. Street and Number 10g. Citizen of What Country? f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a o other traumatic event, the Medical Examiner must be Funeral death with 20833 USA 19109 Georgia Avenue, Apt. 221 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Forces' Black, White, etc. 1 X Yes 2 No Completed by 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: 3XXWidowed 4 ☐ Divorced Year or Dates.1942-45 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 3 Federal Government Contracting Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Angelina Ristuccia Joseph Amato 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 852 Quince Orchard Blvd. #101, Gaithersburg, MD 20878 Anna Maria Amato/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot Arlington National Cemetery Crematory or other place Arlington National Cemetery Jan 5 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington, VA 21. Signature of Funeral Service Licensee rancis J. Collins Funeral Home Inc. 500 University Blvd..W, Silver Spring, MD 20901 23a. Part Y. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 3 yrs shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Ischemic Cardiomyopathy disease or condition resulting in death) yrs Medical Due to (or as a consequence of) Examiner 40 yrs Coronary Atherosclerosis Sequentially list conditions. cause (Disease or linjury Due to (or as a consequence of) death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a Physician/Medical Bax 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Other (specify) Pregnant at time of death 1 Yes 2 No the g Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death,

To the Funeral Director, After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach. Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No autopsy performed? Yes 2 X N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Assisted Living Other: ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 🔀 Natural injury 5 Pending 2 Accident Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d, Date signed (Month, Day, Year) D35045 December 18, 2011 d cause of death (Item 23a) (Type, Print) 18109 Prince Philip Drive, #200, Olney, MD 20832 Name and address of person v Philip Henjum, MD

State Registrar 31. Date filed (Month, Day, Year)
DEC 2 0 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 12:05 PM Physician/ Dec. 2011 Awalt William Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Potomac Byron House If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9, Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number Funeral Nov. 3,1922 Months Days Hours 1 X M 2 □ F Baltimore, MD 89 220-44-5479 Director Usual Residence of Decedent 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Potomac Montgomery Md. 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A 20854 9210 Kentsdale Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🖾 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No If Yes Give "natural", 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 16b Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) iife. DO NOT use retired) Roman Catholic Priest nd Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Roman Catholic Church Be other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Mary Molz William J. Awalt, Sr. is ma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 29260 Washington, D.C. 20017 Health attem 27 i Joseph A. Ranieri/Adminstrator t: If item 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Gate of Heaven Cemetery ō 1 🗵 Burial 2 🗆 Cremation 3 🗔 Removal from State 21, Dec. 2011 permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Md. 21. Signatur 1 uneral Service Dicense 22. Name and Address of Facility DeVol Funeral Home MO1315 D.C. 20007 2222 Wisconsin Ave. N.W. Washington, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
Weeks Immediate Cause (Final <u>Congestive Heart Failure</u> Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Years Ischemic Cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Que to (or as a consecuence of): Examine for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending IE FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Pregnant at time of death Ectopic pregnancy 3 in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year g 🔲 Unknown the is been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nis certificate has b I director, page 2 s autopsy performed? Yes 2 No 1 Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical Assisted Living 6 X Other (Specify) examiner? Other: 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence မှ After this 28a. Date of injury 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: injury (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Investigation 6 Could not be Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

death. within 24 hours after death

To the Funeral Director: of

2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401 MacArthur Blyd. N.W. Washington, D.C. 20016 Marta A. Schneider M.D.

32. Registrar's Signature

State Registrar

DHMH 17 Rev 7/2009

10

Medical

29a. Certifier

(Check

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)
DEC 2 0 2011

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License numbe

MD12224

29d. Date signed (Month, Day, Year)

2011

December 19,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ <u>Esfira N. ALTMAN</u> December 2011 11:45 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 352 Chestertown Street Montgomery Gaithersburg Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Jan. 15 9. Birthplace (State or Foreign Country) Belarus 7. Age (In vrs. last birthday) **Funeral** 1 M 2 X F **Director** 149-88-5425 90 Jan Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State irector 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🕅 No Maryland Montgomery <u>Gaithersburg</u> ۵ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 352 Chestertown Street 20878 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🚺 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married ð Maryland 21215-0036 1 Yes 2 No Specify: Specify: white Completed 3 🕅 Widowed 4 🗆 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) je 1 and 2 should be filed within 72 t of Health and Mental Hygiene. If item 27 is marked other than in Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rifka Slonovich Neukh Kats 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Inna Etin, Daughter 352 Chestertown St., Gaithersburg, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place Judean Memorial Gardens 12/16/11 Olney, MD 21. Signature of funeral Service Licensee Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, 20012 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ CAN CER DIE Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cauca. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury Due to (or as a consequence of): resulting in death) Last nding physician use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Live Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Dav Year Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performe 1 Yes 2 No Yes 2 N Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 잍 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🗙 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending after death.

Director: Aff 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation within 24 hours after de To the Funeral Directo 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29c. License number D 0061083 December 14, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9707 Medical Center Dr., Ste. #300, Rockville, MD 20850 Paul M. Thambi, M.D., State **DEC 1** 5 2011

Registrar

GIONIA MAY Anthony

				pe or Prin								Legi	ble.	
		1	For State Registrar	State of Ma	ryland	-	artmen <i>tificate</i>				JIENE Reg. No.	20		1 42647
	Physicia		1. Decedent's Name (First, Middle, Last)		_					2. Date of Dea Month	Day	20	Year,	3. Time of Death
	Medic Examin		Gloria May Anth 4a. Facility Name (if not institution, give stre				4b. City,	Town, or Lo	ocation of Death	December		County	of Death	
			The Momorial	Hospi	+al		1511	Eas	1011			Ta	bo	+
1	Funeral Director		5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. A ge	(In yrs. las	t birthday) Yrs.	If Under Months		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)			nplace (State or Foreign Intry)
-			Usual Residence of Decedent		85					May 18.	19:	26	{	Ohio 10d. Inside City Limits
	arylanc a-f she fied at	ector	10a. State 10b. County Maryland Caroline			reens								1 Yes 2 TrNo
	the Man or 28	Dir	10e. Street and Number			reens	10f. Zip	Code	···		10g. Citi	izen of W	hat Co	untry?
	th with ms 23e must k	Funeral Director	11760 Greensboro R			Tro v		639	04-1-040	- if y/a- a- Na		USA		
(0	or iter	by Fu	11. Marital Status 1 ☐ Never Married 2 ☒ Married	Mas Decedent Ev Armed Forces? 1 ☐ Yes 2 ☐ N		l II	f Yes, spec	ify Cuban,	panic Origin? (Spe Mexican, Puerto	Rican, etc.)			- Amer , White	ican Indian, , etc.
21215-0036	be filed within 72 hours after death with the Manyland entel thygiene ked althygiene "natural", or items 23a or 28a-f sho ked out, the Medical Examiner must be notified at ic event, the Medical Examiner	ted t	3 Widowed 4 Divorced	If Yes, Give Year or Dates.			Yes	Λ				Specify:		nite
15-(72 ho in "nat	Completed	15. Decedent's Educ (Specify only highest grade	completed)		16a. Deced (Give F life. D	lent's Usua kind of wor O NOT use	k done dur	ion ring most of work	ing	16b. Ki	nd of Bu	siness/I	ndustry
212	within giene. Jer tha t, the I		Elementary/Secondary (0-12)	College (1-4 or 5+	1	Home	emake					amil		
and	ntal Hy ced oth	To Be	17. Father's Name (First, Middle, Last) Silas Anthony Dou	a1 a c				1	18. Mother's Nam	e (First, Middle, 1 Fanny N				
Maryland	nd Mind S mar		19a. Informant's Name/Relationship (Type			19b. Mailin	ng Address	(Street and	d Number or Rur			_	ate, Zip	Code)
Σ	permit. Page 1 and 2 sl Department of Health a Important: If item 27 is any injury or other tra		Samuel L. Anthony/	spouse	_				o Road					Land 21639
Baltimore,	ge 1 a nt of H t: If ite	l	20a. Method of Disposition 1 We burial 2 Cremation 3 Re	moval from State	cei	ace of Dispo metery, cren	natory or o	ther place)		Date				Town, State
altin	mit. Pa bartme bortani injury		4 Donation 5 Other (Specify) 21. Si ure Funeral Service Lice see	1	Holy	7 Cross	. Name an			//2011 oore Fur				, Maryland P.A.
m	permi Depai Impoi any ir		* Kausapht.	Nove				*****	cond St	reet I	ent (1and 21629
1 TO	executed Medical Examiner ual-transit	Examiner	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C.	Due to or as a	conseque	ence of):	eont Ma	AC)	ilve	or respiratory an				Approximate Interval Between Onset and Death
09		dical E	resulting in death) Last Due to or as a consequence of): d.											
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. Within 25 hours after death. To the Eurorial Director: After this certificate has been signed by the attending physici. To the Eurorial Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but the funeral director.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	Fetal	death 3	Ectopic Other (sp					23d. Dat Moi		ivery Day Year
s, P.O.	requires that the death been signed by the atte should be detached for	by	Part II. Other significant conditions cont	ributing to death bu	t not resu	Iting in the u	ınderlying (cause give	n in Part I.					the cause of death?
Division of Vital Records,	The law requate has been page 2 shou	Completed								24a. Was autop perfo 1 \(\sum \) Yes	rmed?	i c	rior to d leath?	topsy findings available completion of cause of
ital	ician: The certificate rector, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 Alo	spital:				Other	ce of Death (Chec					
n of V	To the Hospital or Attending Physician: Within 24 hours after death and the Funeral Director. After this certific completely filled in by the funeral director,	cate: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	1 N Inpatie 28a. Date of injury (Month, Day,	/ 2	ER/Outpatier 28b, Time of injury		8c. Injury a work?		ome 5 Residence 28d. Describe h				ıry)
Divisio	Hospital or Attending 24 hours after death. Funeral Director: After stely filled in by the fune	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.		ne, farm, str	eet, factor						ral Route Number,	
_	ne Hospital in 24 hours ne Funeral pletely filled	Medical	29a. Certifier (Check (Check only one) (Check only one) (Certifying Nurse only one)	r: On the basis of ex	amination	and/or inves	tigation, in	my opinion	, death occurred a	it the time, date a	nd place	, and du€	to the	cause(s) and manner stated.
	To the within 2 To the comple		29b. Signature and title of certifier	raf N	7			: License r			12/	122		n, Day, Year)
			30. Name and address of person who con	npleted cause of de	ath (Item :	23a) (Type, F	Print)	ملاي	5976.	0 2	216	100		
	Sta Registra		31. Date filed (Month, Day, Year) DEC 2 7 2011	37 Registra	r's Signatu	. 4	who							

DHMH 17 Rev 06-2011

		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Certificate of Death Reg No. 2 0			
Physici	an/	Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Teresa Linette Bethea Certificate of Death 2. Date of Death 7:48 A _M			
Medi Exami		4a. Facility Name (if not institution, give street and number) 1131 University Blvd., W., Apt. 1209 4b. City, Town, or Location of Death Silver Spring 4c. County of Death Montgomery			
Funeral Director		5. Social Security Number 214-02-0468 6. Sex 7. Age (In yrs. last birthday) 1 \(\text{ Months} \) 45 Yrs. 1 \(\text{ Months} \) 1 \(
Maryland 28a-f show otified at	Director	Usual Residence of Decedent 10a. State			
s 23a or 3	Funeral D	10e. Street and Number 1131 University Blvd., W., Apt. 1209 10f. Zip Code 20902 10g. Citizen of What Country? USA			
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married 1 Yes 2 No			
21215-0036 within 72 hours after glene. "natural", o er the Medical Exam	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Service Representative Logistics Company			
Maryland 2 should be filed to the and Mental Hyg 27 is marked oth traumatic event.	To Be	17. Father's Name (First, Middle, Last) Dock Bethea Jr. 18. Mother's Name (First, Middle, Maiden Surname) Mattie L. Edwards			
, Man, id 2 should salth and h n 27 is me er traume		19a. Informant's Name/Relationship (Type, Print) Mattie L. Bethea / Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1131 University Blvd., W., Apt. 310, S.S., MD 20902			
Baltimore, bermit. Page 1 and Department of Hes mportant: If item any injury or othe		20a. Method of Disposition 1			
Depart De		21. Signatur of Juneral Home, Inc. Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 2090			
Ph, sician Medical Examiner	١.	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ATHEROSCLEROTIC GROIDVALCULAR DISEASE Due to (or as a consequence of): Sequentially list conditions.			
te be executed hysician and he burial transit	dical Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit.	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1 Yes 2 No 9 Unknown Unknown Unknown 23c. If yes, outcome of pregnancy 23d. Date of delivery 23d. Date of delivery 23d. Date of delivery Month Day Year			
requires that the despense signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Yunknown			
ician: The law requirector, page 2 short	Completed	HTPERTENSION, OBESITY 1 Yes 2 No 3 Probably 4 Munknown SEIZURE DISORDER, ASTHMA 24a. Was an autopsy performed? performed? death? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 2 No 3 Probably 4 Munknown			
ing Physician: The law requires After this certificate has been sig	ate: To Be	25. Was case referred to medical examiner? 1			
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral process.	Certificate:	Accident 3 Suicide 4 Homicide Investigation Suicide	he Hospiti in 24 hours he Funera pletely fille	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
withi vithi		(Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASHA VALI, GSOI, BEORGIA AV, SILVER SIRING MD 22 31. Date filed (Month, Day, Year) DEC 16 2011 32 Registrar's Signature			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASHA VALI, 9801, BEORGIA AV., SILVER SORING MD 20			
Sta Registr		DEC 16 2011 32/Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

	F	- For State tegistrar		C	ertificate	of	Death				Reg. No.	21		1 425) 4
Physiciar Medical Examin		1. Decedent's Name (First, Middl Cody Eman	anuele Butz							2. Date of Death Month Day December 21, 2011 3. Time of Death 1349 hrs					
		ta. Facility Name (if not institution 15945 Broadfording R		umber)		41	b. City, Town, or Hagerstown		f Death	4c. County of Death Washington					
Funeral Director	Director 216-39-3469 1 N 2 F 18 Yrs. Months Days Hou							Min.	8. Date of B 6 – 11	irth (MM/I - 19	93	Foroign	nplace (State or n intryMD		
and f show any nuce.		Jsual Residence of Decedent 10a. State 10b. County MD Wash	ington		ty, Town or I									10d. Inside City Li 1 Yes 2 2	
with the Maryland ms 23a or 28a-f sho be notified at once		10e. Street and Number 15945 Broad	lfording	Road			10f. Zip Code 2174	10				en of Wha		ry?	
fler death	悪し		Armed F 1 Yes Orced If Yes, Give Yes	2 X No		If Ye	Decedent of His s, specify Cubar Yes 2 X No	specify:	Puerto Ri	can, etc.)	\$	White	whi	_	
11215-0036 Id be filed within 72 hours a fental Hygiene, arrived other than "natural recent, the Medical Examinators.	mpleted	15. Decedent's Education (Spec Elementary/Secondary (0-12) 11th grade	College (de completed) 1-4 or 5+)	d uri	ng mo	s Usual Occupat st of working life Ltor	. DO NOT u	ise retired	inventor control b			У	3	
21215-0036 Buld be filed within 7 Mental Hygiene marked other than e event, the Medica	8	7. Father's Name (First, Middle, Guy A. Butz	Jr.					Car	in	irst, Middle, D • Ho	rsle	ЭУ			
MD 2 nd 2 should alth and M em 27 is m		19a. Informant's Name/Relations Carin Treca		201	115	945	Address (Stree Broad	liord	ling	Rd.H	age:	rsto 	wn,	Zip Code) MD 217	74 u
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 XBurial 2 Cremation 4 Donation 5 Other Sp	pecify:		Garde	or othe	di Fait	h	12-		W)	hite	e Ma	rsh,MD	
	+	21. Signature of Funeral Service	DAVIS	ouned the deco	Ī	Ρ.	O.BOX	310	Cle	ar Sp	rin	g, M	ID 2	Home,Ir	
Physician /Medical £xaminer		3a. Part I. Enter the disease, or failure. List only one cause immediate Cause (Final disease or condition resulting in death)					e mode or dying,	such as car	rdiac or re	espiratory an	rest, snoo	ж, ornea	п	Approximate Inte Between Onset a Death	
	ıner	Sequentially list conditions, f any, leading to immediate cause. Enter Underlying Cause	b. Due to (or as a									_			
760, ficate be executed g physician and r the burial - transit	Ka	Cituate or injury that initiated events resulting in death) Last	Due to (or as a	a consequence	of):										
ficate be ex g physician : the burial	Medical	UNPENDED F FEMALE:	AMENDED								004	D-11			_
ox 68 ath certi		3b. Was decedent pregnant in th past 12 months?	e 1 Live b	ant at time of	2	-	Il death 3 [er (Specify)	Ectopic p	pregnanc	у		Date of o	Da	ay Year	-
ires that the de signed by the	6	art II. Other significant conditi	ons contributing to	o death but not	t resulting in	the un	derlying cause g	iven in Part	t I.					ne cause of death?	
of Vital Records, ag Physician: The law requirement of the thin the law requirement of the thin the th	Сощріетей							•		24a. Was autor perfo		pr de		opsy findings availant opposy findings availant opposition of cause	of
tal Recting The certificate ector, page		5. Was case referred to medical examiner?						of Death (C	Check onl			<u> </u>			
ion of Vit tending Physic eath. or: After this the funeral dire	<u>•</u>	1 ✓ Yes 2 No 7. Manner of Death 1 Natural 5 Pend	28a. Date		ER/Outpa 28b. Time FOUND	of Inj	ury 28c. Injur	Other ₄ y at Work? 'es 2 ✓ N	28	fome 5 d. Describe ubject har	how injur	у оссиле		Scene	_
	וט	3 Suicide 6 Could	not be				factory, office b		28	or Town, S 945 Broadi	State)			al Route Number, C	City
9 - 3 ->	e 1	9a. Certifier 1 Certifying Ph	nysician: To the besoniner:On the basis and manner s	of examination				-			. ,				
	2	9b. Signature and title of certifie			15	7	29c. Licenso					ate signe ember 2		th, Day, Year)	
IN-3		0. Name and address of person Russell Alexander MD	. Assistant N	fu.		00 V	V. Baltimore	Street, B	Baltimor	e, MD 21	223				\dashv
Stat Registra	te ³	1. Date filed (Month, Day, Yar)	2011 32. R	gistrar's Signa		6.	K								
DHMH 17 Rev 1/200	_				ORIGI				<u> </u>	er' • sa					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 42650

		1- For State Registrar	Cert	tificate of	Deatl	h		Re	g. No.	201	1 7200
	Physician/ 1. Decedent's Name (First, Middle,Last) edical Examiner MARK WEBSTER BIERMAN 2. Date of Death Month Day Y December 27, 2011							3. Time of Death			
ledical Exami	ner	MARK WEBSTER BIERMAN						December			1320 hrs
W. Cond		4a. Facility Name (if not institution, give street and number) 21 1st Avenue		4	b. City, T Better	own, or Locati Inform	on of Death			c. County of Deat Kent	h
Funeral			(In vrs. la	st birthday)			Jnder 24Hrs.	8. Date of Birt			rthplace (State or
Director		214-68-7020 1XM 2DF		**	Month		ours Min.			Forei	gn MARYLAND
		Usual Residence of Decedent	55	Yrs.				DEC.9,	15	956 "	Janay)
any	ı		10c. City,	Town or Locati	on						10d. Inside City Limits
and show	5	MD KENT	E	BETTERT	ON						1 X Yes 2 No
Maryland 28a-f sho d at once	Director	10e. Street and Number			10f. Zip	Code		10	0g. Cit	tizen of What Cou	intry?
h the 3a or		21 FIRST AVENUE				21610				USA	
215-0036 be filed within 72 hours after death with the Maryland nial Hygione. rked other than "natural", or items 23a or 28a-f sherent, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?	Ever in U.S	5. 13. Was	Decede s, specif	nt of Hispanic y Cuban, Mexi	Origin? (Spi ican, Puerto I	ecify Yes or No- Rican, etc.)		14. Race - Ame White, etc.	rican Indian, Black,
er dea		1 Yes 2	X No	1	Van al	X No spec	eit u				II T m m
urs afi tural'	d by	15. Decedent's Education (Specify only highest grade com	pleted)	16a. Decedent				ork done	16b.	Specify: W Kind of Business	HITE /Industry
72 ho	Completed	Elementary/Secondary (0-12) College (1-4 or 5		during mo	st of wor	king life. DO N	IOT use retir	ed)			•
5-0036 iled within 72 Hygiene. I other than '	E E	12 4		SALES	SMAN					RETAIL	
5-0 illed v Hygi d other		17. Father's Name (First, Middle, Last)				18.Mol		(First, Middle, N	/laider	Surname)	
ID 21215-00; should be filed within and Mental Hygiene. 7 is marked other than the Medic of the	o Be	WEBSTER BIERMAN 19a. Informant's Name/Relationship (Type, Print)		40h Mailine	A 444	(2)		HARDY			
MD 21 12 should th and Me 27 is ma umatic cv	욘	JOANNE BIERMAN LUCAS/SISTE	R							City or Town, Stat	
and and lealt transfer		20a. Method of Disposition	20b. P	lace of Disposi	tion (Nam	ne of cemetery	',	Date		Location - City o	
nor of unit of other		1 Burial 2 X Cremation 3 Removal from Sta	-	SAPEAK	er place)	EMATION			_ ا	TENENCUT	TIE MD
Baltimore, permit. Pages I and Department of Healt Important: If item injury or other trai		4 Donation 5 Other Specify: 21. Sign tune of Funeral Service Liqensee	CE	NTER 22. N	ame_and	Address of Fa	201	L1	3	TEVENSV1	LLE, MD
E E S Z M	e s	Hary B Fellows		FEI	LOWS SPE	S,HELFE EER ROA	NBEIN D. CHI	& NEWNA STERTON	AM JN	FUNERAL	HOME, P.A.
Physician		23a. Part I. Erte the disease, or complications that caused failure. List only one cause on each line.	the death.	Do not enter th	e mode o	of dying, such a	as cardiac or	respiratory arre	est, sh	ock, or heart	Approximate Interval Between Onset and
cal mer		Immediate Cause (Final disease a. Complicati			nic	alcoho:	1 abus	e			Death
		or condition resulting in death) Due to (or as a conse	quence of):		-					
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a conse	quence of):							
Couse. Enter Underlying Cause C. (Disease or injury that initiated C.											
ansit	E	events resulting in death) Last Due to (or as a conse	quence of):							
760, cate be executed physician and he burial - transi	ical	▼ UNPENDED AMENDED 23a,	pt.I	1,27,pe	r me	,g923	1-31-1	2 sm			
760, icate be ex physician the burial	Medical	IF FEMALE: 23c. If yes, outcom	e of pregn	ancy					23	3d. Date of delive	J
		23b. Was decedent pregnant in the past 12 months?		=	al death	3 Ect	topic pregnar	псу			Day Year
Box death c death c	Physician	1 Yes 2 No 9 Unknown 9 Unknown	ime of dea	oth 5 Oth	er (Spec	cify)					
t the d		Part II. Other significant conditions contributing to death	but not re	sulting in the u	nderlying	cause given ir	n Part I.	23e. Did to	bacco	use contribute to	the cause of death?
P.O.	ğ	Diabetes Mellitus, Obesit	у					1 Yes	2	No 3 Pro	babiy 4 🗹 Unknown
of Vital Records, graysician: The law require this certificate has been sineral director, page 2 should be need the standard of the control o	Completed							24a. Was a			utopsy findings available
eco he law ite has	Ĕ							autop perfor	med?	death?	completion of cause of
tal Rec	0	25. Was case referred to medical				26.Place of De	ath (Check o		2[N	No 1	es 2 No
Vitins of I direct	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatier	nt 2 🗌	ER/Outpatient	3 🔲 D	OA Other	4 Nursing	Home 5	Resid	ence 6 🗸 Othe	er: Scene
ing Pl	١	27. Manner of Death 1 X Natural 5 Paneline 28a. Date of Injur (Month, Day, Ye	y par)	28b. Time of Ir	ijury 2	28c. Injury at W	Vork?	28d. Describe h	now inj	jury occurred	
Sion ttend death. ctor:	atio	2 Accident Investigation				1 Yes 2					
Division tal or Attendi rs after death. al Director: A	Certification:	3 Suicide 6 Could not be 28e. Place of Inj	ury - At ho	me, farm, stree	t, factory,	, office building	g, etc.	28f. Location (S or Town, S		and Number or R	ural Route Number, City
in in in in in in in in in in in in in i		4 Homicide determined (Specify) 29a. Certifier 1 Certifying Physician: To the best of my									
To the Ho within 24 } To the Fu	Medical	(Check only	knowledg nination an	e, death occur id/or investigat	red at the on, in my	time, date and opinion, death	d place, and h occurred at	due to the caus t the time, date :	e(s) ai	nd manner as sta	ted. he cause(s)
To To com	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year,										
	O.C.M.E. December 28, 2011										
30. Name and address of person who completed cause of death (Item 23a)											
		Zabiullah Ali, M.D. Assistant Medical Ex	aminer	900 W. B	altimore	e Street, B	altimore,	MD 21223			
St	ate	31. Date filed (Month Day, Year) 2012 32. Tegistrar	s Signatur	4 Same	May						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBER 18, 2011 6:25 EDWARD THOMAS BALCER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** QUEEN ANNE'S OUEEN ANNE'S COUNTY HOSPICE CENTER CENTREVILLE Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Hours **Director** <u>212-16-0509</u> 1 🗶 M 2 🗆 F 86 JUNE 4, 1925 MARYLAND Usual Residence of Deced 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and tifem 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** QUEENSTOWN MD QUEEN ANNE'S 1 Yes 2 X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 209 HICKORY RIDGE DRIVE 21658 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married 1 X Yes 2 No-1951 If Yes, Give 1950-1951 Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 Divorced WHITE Completed Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) OWNER/OPERATOR CONVENIENCE STORE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ THOMAS BALCEROWICZ VERONICA GOLAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 209 HICKORY RIDGE DRIVE, QUEENSTOWN, MD 21658 OLGA S. BALCER/ WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o XBurial 2 Cremation 3 Removal from State DEC. 22, EASTON, MD WOODLAWN MEMORIAL PARK 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician Medical Examiner DEPENDENT DEABETES MELLING NSULIU Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine and as the burial-trar that initiated events resulting in death) Last attending physician Physician/Medical pe Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Year be detached the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform this certificate 1 ☐ Yes 2 ₩ No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? HOSPICE 2 👿 No Other: 4 \sum Nursing Home 5 \sum Residence မှ 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 \square Pending work? 1 ☐ Yes 2 ☐ No 1 Matural injury 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who co CIGANEK 629 RAILROAD AVENUE, CENTREVILLE, MD 21617 F. 31. Date filed (Month, Day, Year)
DEC 1 9 2011 32. Registrar's Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 12 Physician/ LeRoy Peter Bieber 2011 9:00 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 11513 Manklin Creek Rd. Ocean Pines Worcester 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** Months Days Hours 1 🛛 M 2 🗆 F 6/29/1938 73 Director 053-30-0972 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Worcester Ocean Pines 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? by Funeral and 2 should be filed within 72 hours after death with Health and Mental Hygiene. 11513 Manklin Creek Rd. 21811 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 1.1 Marital Status 14. Bace - American Indian. Armed Forces?

1 Yes 2 XNo Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify. If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates white 27 is marked other than "natur traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Industrial 12 Printer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ LeRoy Bieber Emily Colinot 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21811 item 27 11513 Manklin Creek Rd Janice Bieber Ocean 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place. 20c. Location - City or Town, State Department of H Important: If ite or 1 🖾 Burial 2 🖵 Cremation 3 Removal from State injury o 4 Donation her (Specify) Franklin Nem. Cem 12/22/2011 New Brunswick, 21. Signature of Fun Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1 nter the or hear failure. List only one cause on Immediate Cause (Final disease or condition cevel Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of) physiciar Physician/Medical as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Tetal death 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) _ in the past 12 months? for Month Year Day Pregnant at time of death detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à be The law requires 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes Yes To the Hospital or Attending Physician: 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 2 No ၉ 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 I Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred s after death. Natural Pending 1 Yes 2 🗌 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one Certifying Nurse-Rractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 7 29b. Signatu

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records.

Division of Vital

30. Name and address of person who completed cause of death (Item 23a) (Type,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Thomas Edward Bry	yant State	e of Maryland / De	epartment of Certificate of		Mental Hy		20	11 4265
Physician/	Registrar 1. Decedent's Name (First, Middle,L		20/11/10410 0/	Dodin		2. Date of Death	g. NO.	3. Time of Death
Physician/ Medical Examiner		Bryant, Sr.		J.D. 4b. City, Town, or L	ocation of Death	Month December	Day Year 9, 2011 4c. County of D	2037 hrs
	Route 33 at Blueberry L			Easton	occupit of Boden		Talbot	
Funeral			rs. last birthday)	If Under 1 Year	If Under 24Hrs.	8. Date of Birth		9. Birthplace (State or
Director	420-44-6290	X м 2 F 75	Yrs	Months Days	Hours Min.	01 /	17/1936	oreign Country) AL .
	Usual Residence of Decedent							Land to the On Horse
nd show any ice.	10a. State 10b. County Md. Talk		City, Town or Locat	Eastoi	n			10d. Inside City Limits 1 Yes 2 No
the Maryland or 28a-f show tified at once. Director	10e. Street and Number 26256 Miles Vie	w Road		10f. Zip Code	1601	10	g. Citizen of What U.S.A.	Country?
er death with it, or items 23.	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 XDivorce	ted If Yes, Give Year Air	lf Y	is Decedent of Hisp es, specify Cuban, Yes 2 X No	Mexican, Puerto		White, e	American Indian, Black, otc. hite
urs afte	15. Decedent's Education (Specify	only highest grade complete	d) 16a. Deceder	nt's Usual Occupation			16b. Kind of Busin	ess/Industry
5-0036 ed within 72 hour 14 yeare. other than "natu the Medical Exam Completed	Elementary/Secondary (0-12) 12	College (1-4 or 5+) 5+		ical Doc		eaj	Health	Care
MD 21215-0036 d 2 should be filed within 7 lith and Mental Hygiene. In 27 is marked other than numatic event, the Medica To Be Comple	17. Father's Name (First, Middle, La	dward Bryant	'	1	8.Mother's Name Alik	oe l	Nettle	
MD 21 2 should 1 2 should 1 27 is man To	19a. Informant's Name/Relationship Thomas E. Bryan			Address (Street Volta Pl		. Washin	gton, D.	C. 20007
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene, Important: If item 27 is marked other it injury or other traumatic event, the Med	20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other Spec	3 Removal from State	crematory or other control con		.	Date L4-2011	Delmar,	
Baltir permit. P Departme Importar injury or	21. Signature of Funeral Service Lie		SA P.	Freyd Address O. Box 51	trowski 8 St. M	Funeral ichaels,	Home P. Md. 216	A. 63
Physician	23a. Part I. Enter the disease, or co failure. List only one cause on	mplications that caused the d		he mode of dying, s	uch as cardiac or	respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
* /Medical Examiner		a. Multiple Injuries Due to (or as a consequent	ice of):					Death
.	Sequentially list conditions, if any, leading to immediate	b	ice of):					
ted Insit Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequen	ce of):					
execution and in and in tra	UNPENDED	d AMENDED		<u></u>				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buriledical Certification: To Be Completed by Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of deliver 23b. Was decedent pregnant in the past 12 months?							
P.O. By that the de interest of the detached for by Phy	Part II. Other significant condition		not resulting in the	underlying cause gi	ven in Part I.			te to the cause of death? Probably 4 Unknown
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death. a) Director: After this certificate has been signed by ted in by the funeral director, page 2 should be detach ertification: To Be Completed by P						24a. Was a autops perform	n 24b. We sy priced? dea	re autopsy findings available or to completion of cause of
tal Rician: T	25. Was case referred to medical			- 12	of Death (Check	only one)		
F Vit. Physici	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2					Residence 6 🗸	
on of ending P ath. or: After the funera	27. Manner of Death 1 Natural 5 Pendin		28b. Time of 0000 hrs			28d. Describe h Subject drive up head on	ow injury occurred er weaving in t	raffic and struck pick-
Division o spital or Attending nous after death. neral Director: After filled in by the fune Certification:	2 ✓ Accident Investig 3 Suicide 6 Could r determ	28e. Place of Injury -				or Town, St		or Rural Route Number, City aston, Md.
To the Hospital within 24 hours To the Funeral completely filler		sician: To the best of my kno ner:On the basis of examinati and manner stated						
A E SE S	29b. Signature and title of certifier	ten Week	noso	29c. License O.C.M			29d. Date signed December 10	(Month, Day, Year) D, 2011
	30. Name and address of person w							
5+VA	Victor Weedn MD JD	Assistant Medical Exa	aminer 900 V	V. Baltimore St	reet, Baltimo	re, MD 2122	3	
State	31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature	31. Alex				

11-09741 Judith Bell

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Jaitu Reii		State of Maryland 1- For State Registrar	•	ficate of t		iu ivient		teg. No. 20	11 4265
Physicia Medical Examir	n/	Decedent's Name (First, Middle,Last)				· -	2. Date of Dea Month December	Day Year 27, 2011	3. Time of Death 1616 hrs
		Judith Ann Bell 4a. Facility Name (if not institution, give street and number)			. City, Town, o			4c. County of	Death
		Calvert Memorial Hospital	e (In yrs. last		Prince Fre		24Urn I Pata of Pi	Calvert	9 Pirthplace (State or
Funeral Director		216-42-0678 1_M 2XF	66	Yrs.	Months Da	_	Min. 02-08	F	9. Birthplace (State or Foreign Ohio
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Location	1				10d. Inside City Limits
Aaryland 28a-f show 1 at once.	ō	MD Calvert				Lusby			1 Yes 2 X No
ith the Maryland 23a or 28a-f sho notified at once,	Director	10e. Street and Number			10f. Zip Code	20657		10g. Citizen of What	: Country?
with th		344 Oak Drive 11. Marital Status 12. Was Decedent			Decedent of H		n? (Specify Yes or No		American Indian, Black,
death or item	Funeral		X No		77		Puerto Rican, etc.)	White,	atc.
rs after ural", miner	à	3 Widowed 4 X Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade con	inleted) I1		es 2 X N		ind of work done	Specify: 1	
72 hour	Completed	Elementary/Secondary (0-12) College (1-4 or			t of working lif				,
within jene.	E C	12 17. Father's Name (First, Middle, Last)		Securi	ty Off	icer,	Guard Name (First, Middle,		Power Plant
	Be C	Malcolm Milburn MacKe	nzie			Rox			3
212 hould bend Menis mark	2	19a. Informant's Name/Relationship (Type, Print)			•	et and Numb	per or Rural Route Nu	mber, City or Town,	
, MD and 2 sho eaith and em 27 is	- 1	Heather Bell Roark, Daught		156 ace of Dispositi			Road, Prin	.ce Freder 20c. Location - C	rick, MD 20678
Baltimore, permit. Pages I an Department of Hec Important: If ite Important: If ite		1 Burial 2 X Cremation 3 Removal from St	11.0	ematory or othe			12_20_11	Alexand	Trio VA
altin mit. P. partmet portan	i	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Trieti	22. Na	me and Addre	ss of Facility	12-30-11 Rausch Fu	neral Hom	ne, P.A.
	- 11	23a, Part I, Enter the disease, or complications that caused	M00715	5 832	5 Mt. 1	Harmon	y Lane, Ow	ings, MD	20736
Physician Medicul		failure. List only one cause on each line.							Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Hypertens Due to (or as a const		.nerosc.	rerocio	caru.	iovascutar	Disease	
	<u>_</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a const	guence of):						
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated							
uted nd ransit		events resulting in death) Last Due to (or as a const	squerice or).	_					
60, ate be executed hysician and e burial - transit	ledical	▼ UNPENDED ☐ AMENDED 23a			r me,g	923 1-1	12-12 sm		
Box 68760, e death certificate be the attending physic of for use as the bur		IF FEMALE: 23c. If yes, outcor 23b. Was decedent pregnant in the	ne of pregna	(death 3	Ectopic	pregnancy	23d. Date of de Month	elivery Day Year
cox 6876 eath certificate attending phy for use as the l	Physician/N	past 12 months? 1 Yes 2 No 9 V Unknown	time of deat	_ =	r (Specify)			8	
D. Be		Part II. Other significant conditions contributing to deat	but not resi	ulting in the un	derlying cause	given in Par	t I. 23e. Did t	obacco use contribu	ute to the cause of death?
rics that the signed by	d b	Chronic Bronchitis					1 Ye	s 2 No 3	Probably 4 Unknown
ords w requas been	ompleted						24a. Was	psy pric	ere autopsy findings available or to completion of cause of
tal Records, cian: The law require certificate has been si ector, page 2 should tector,	S						1 Yes	ormed? dea 2 ✓ No 1	ath? Yes 2 No
of Vital Rec ng Physician: The 	o Be	25. Was case referred to medical examiner? Hospital: 1 Inpatie	nt 2 🗸 E	R/Outpatient			Check only one) Nursing Home 5	Residence 6	Other:
of Ving Phy		1 ✓ Yes 2 No Impatte 27. Manner of Death 28a. Date of Inju. (Month, Day, Y	ry 2	8b. Time of Inj		jury at Work?	28d. Describe	how injury occurred	
Division tal or Attendi rs after death. al Director: A led in by the fu	gi	Natural 5 Pending 2 Accident Investigation				Yes 2 1		Ctook and Norther	or Dural Doute Number City
Divis	ertification	3 Suicide 6 Could not be determined (Specify)	jury - At nom	ie, rami, street,	ractory, office	building, etc.	or Town,		or Rural Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	ledical C	29a. Certifier 1 Certifying Physician: To the best of mone) 2 Medical Examiner: On the basis of examiner.							
To To	Me	29b. Signature and title of certifier			29c. Licer	nse number			(Month, Day, Year)
		myn			0.0	.M.E.		December 2	8, 2011
		30. Name and address of person who completed cause of c Ling Li, MD Assistant Medical Examine			Street, Ba	iltimore, M	1D 21223		
	ate	31. Date filed (Month, Day, Year) 32. Registra	r's Signature		Ke)				
Regist	ŒЦ	THIS TO MILL (MAIL	A D	1 sugar					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 December 3:39 A M BALLENGER MARIE MABLE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 0339 Rockville Montgomery Shady Grove Adventist Hospital 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Days Hours Min. 215-94-6671 **Director** 1 □ M 2 🕱 F 0 12/18/1923 Maryland 87 Usual Residence of Deced 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits aţ Director Examiner must be notified 1 🗆 Yes 2 💢 No MD Montgomery Boyds 10f. Zip Code 10e Street and Number ō 10g. Citizen of What Country? Funeral items 23a 20841 United States 19925 White Ground Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 XWidowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Health and Mental Hygiene. tem 27 is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) 10th College (1-4 or 5+) Own Home Homemaker injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nellie Buchman May William Clarence Huff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Frederick, MD 21704 5761 N. Mayer Drive, Mable M. Sizemore, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Boyds Presbytellan 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify 12/19/2011 | Boyds, Maryland Church. Cemeteru 21. Sign nure f Funeral Servic 22. Name and Address of Facility Simple Tribute Funeral/Crem. Ctr. M00709 Rockville. MD 1040 Rockville Pike, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Cardio Physician/ pulmonar disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events 6 cholecustitis To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of resulting in death) Last Physician/Medical Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown ģ Month Day the 9 Unknown signed by t. Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform Yes Division of Vital 25. Was case referred to medical director Be 26. Place of Death (Check only one) Hospital 2 🕅 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) J. 28c. Injury at work? 27. Manner of Death Date of injury (Month, Day, Year) Certificate: 28d. Describe how injury occurred iniurv 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director, Af 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Cartifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature 29d. Date signed (Month, Day, Year) M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10110 molecular Dr Suite 206 Rockville, mg 20850 Marichu Matas MD 1. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ December 2011 7:30am Scott Wood Brandon Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 19310 Club House Road #322 Montgomery Village 9. Birthplace (State or Foreign Social Security Number . Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours 1 ፟ M 2 □ F March 26, 1920 91 Yrs. Utah **Director** 553-12-3435 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d, Inside City Limits 10b. County 10a. State Director |Maryland Montgomery Montgomery Village 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 20886 United States 19310 Club House Road, #322 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Give Year or Dates White 3 ¥ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government 5+ Public Health Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Pauline Wood Earl Brandon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Turnham Lane, Gaithersburg, MD 20878 Julie Coleson (Daughter) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 X Cremation 3 Removal from State Metropolitan 19 December 4 Donation 5 Other (Specify) 2011 Alexandria, Virginia Crematory DeVol Funeral Home, 22. Name and Address of Facility 21. Signature of Funeral Service, License 10 E. Deer Park Drive, Gaithersburg, MD 20877 M00689 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Aspiration Pneumonia Hours Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Months Lung Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transity. Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy
performed?

1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 K Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27 Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

Division of Vital Records, P.O. Box 68760

Registrar

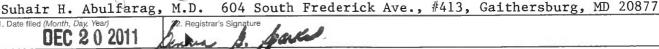
Medical

29a. Certifier

only one) 29b. Signature and title of certifier

31. Date filed (Month, Day, Year) DEC 2 0 2011

30. Name and address of person who complete



cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) December 19, 2011

29c. License number

D31391

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	State of Maryland / Dep.	artment of Health and rtificate of Death		7111	42657
			Registrar 1. Decedent's Name (First, Middle, Last)	inicate of Death	2. Date of Death	g. No. C 0 1 1	3. Time of Death
	Physicia Medic		Mary D. Brady		December	16 2011	6:25 a M
	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat	th	4c. County of Deat	h
			6013 10th Place	Hyattsville	1.5.5 (8)	P. G.	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) $481-18-2394$ $1 \square M 2 \mathbb{Z}$ F 90 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.			hplace (State or Foreign untry)
		i.	481-18-2394 1 □ M 2 🗷 F 90 Yrs. Usual Residence of Decedent		May 12,	1921 I	
	rland f shov	tor	10a. State 10b. County 10c. City, Town or Lo				10d. Inside City Limits
	Many 28a-	Director	MD P.G. Hyattsvi			611	1 Yes 2 X No
	ith the	ral	10e. Street and Number 6013 10th Place	10f. Zip Code 20782		og. Citizen of What Co USA	untry?
	ath w	Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (S	Specify Yes or No-	14, Race - Ame	rican Indian,
٥	or its	by F	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒No	If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☒ No Specify:	to Rican, etc.)	Black, White Specify: Wh1	
200	urs af ural", al Exa		3♠ Widowed 4 □ Divorced Year or Dates.				
5-	72 ho	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	orking 1	16b. Kind of Business/	Industry
12	ithin iene.	Con	Elementary/Secondary (0-12) College (1-4 or 5+) Anal			Federal G	overnment _
פַ	be filed within 72 hours after death with the Maryland antal Hygiene. Add other than "natural", or items 23a or 28a-f show ked other than "natural", or items 23a or 28a-f show to event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)	18. Mother's Na	ame (First, Middle, Ma	aiden Surname)	
ylar		욘	Joseph Stueve		. Kruse		
Maryland 21215-0036	should be file and Mental H is marked of raumatic ever		4	ing Address (Street and Number or Ri			
e G	1 and 2 should be of Health and Men item 27 is marke other traumatic		Catherine Brady McClave/Daughter 11 20a. Method of Disposition 20b. Place of Disp	319 Rolling Hous		ockville, 20c. Location - City or	
nor	a. U 4- 1-		1 N Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, cre	matory or other place)		Silver Spri	
Baltimore,	permit. Page Department Important: I any injury o						
ñ	permit. Departr Importa any inji		In Ke Collis My	2. Name and Address of Facility rancis J. Collins 00 University Bly	d. W., Si	Home Inc. 1ver Sprin	ng, MD 20901
H			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.				Approximate Interval Between
معاضور	Phylian/		Immediate Cause (Final disease or condition	ccident			Onset and Death
	Medical Examiner		Due to (or as a consequence of):				
		ē	if any, leading to immediate Cerebrovascular D Due to (or as a consequence of):	1sease			32 vrs
	ted d shsit	Examiner	cause. Enter Underlying Cause (Disease or injury				
	ie be executed iysician and ne butan sasi		that initiated events resulting in death) Last C. Due to (or as a consequence of):				
	te be e	Physician/Medical	d				
289	death certifica he attending pl ied for use as t	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			004 0-4-4	ti.
Box	ath ce attend for us	cian	in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)		23d, Date of de Month	Day Year
, M	requires that the death certificat been signed by the attending ph should be detached for use as th	hysi	1 ☐ Yes XX No 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown				
P.O.	that t ned b e deta	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to	_
ds,	quires en sig ould b	ted	Hypertension		1 □ Ye	s 2 No 3 P	robably 4 🛭 Unknown
CO	aw rei as be	Completed			24a. Was an autopsy	y prior to	topsy findings available completion of cause of
Re	: The l				perform 1 Yes 2		s 2 No
ta	certifi rector	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	26. Place of Death (Ch			
<u>></u>	Phys r this eral di	e: To	27. Manner of Death 28a. Date of injury 28b. Time of	of 28c. Injury at	28d. Describe how	nce 6 Other (Spec w injury occurred	offy)
nc	ath. r: Afte	icat	1 X Natural 5 □ Pending (Month, Day, Year) injury 2 □ Accident □ Investigation	work? 1 ☐ Yes 2 ☐ No			
Division of Vital Records,	r Atte ter de recto r by tl	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Str. City or Town,	reet and Number or Ru , State)	ıral Route Number,
ā	oital o urs af rral Di		X		and due to the equi	and manner as s	tated
	To the Hospital or Attending Physician: The law requires that the within 424 hours dare dealh. To the Funeral Director, After this certificate has been signed by it to the Funeral Director. After this certificate has been signed by it completely filled in by the funeral director, page 2 should be detach	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death only one) 3 Certifying Nurse Practitioner: To the best of my knowledge.	stigation, in my opinion, death occurred	d at the time, date and	d place, and due to the	cause(s) and manner stated.
	T S the	Σ	29b. Signature appriitle of certifier	29c. License number		gd. Date signed (Mont	
	7		VUL SUME	D05120		Dec. 19,	2011
	1		30. Name and address of person who completed cause of death (Item 23a) (Type,		MD 00017		
	-01-		31 Date filed (Month Day Year) #32 Registrar's Signature	y Blvd., Bethesda	/ ۷۵۱/ ساره		
	Sta Registr		DEC 2 0 2011 Augus B. Agas	W.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) December 16, 11:00 AM 2011 <u> Manuel Eduardo Bravo</u> 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda 8. Date of Birth (Month, Day, Y 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. Birthpiac Country) Peru Age (In yrs. last birthday) Hours 1 **X** M 2 □ F 73 Nov. <u> 157-42-5127</u> Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No Rockville Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20852 1 Windermere Court 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give 2 **X** No South American 1 ¥ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Hispanic Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Healthcare Physician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elsa Charcap unknown Bravo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Windermere Court, Rockville, Maryland 20852 Linda Bravo, Spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 12/22/2011 Brentwood, Maryland 21. Signative of Funeral Service Ligensee M01102 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiorespiratory arrest resulting in death) Due to (or as a consequence of) Pneumocystii cannii pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Encephalopathy that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Other (specify) Pregnant at time of death 9 I Inknown II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? Yes 2 X No 1 ☐ Yes 2 ☐ No Was case referred to medical 26. Place of Death (Check only one)

Physician/ Medical **Examiner**

Physician/

Medical

Director

Funeral

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Completed

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2

Examiner

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show or 28a-f shov notified at

"natural", or items 23a o

27 is marked other than "natur r traumatic event, the Medical

permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once.

with the Maryland

72 hours after death

Maryland 21215-0036

Baltimore,

Box

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Records,

Vital

To the Hospital or Attending

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and within 24 hours after death

To the Funeral Director: A

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To Be Completed by Physician/Medical	-
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hysician/	IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2 9 Unknown
ed by P	Part II. Other signif
Be Completed	
To Be	25. Was case referre examiner? 1 Yes 2
ertificate:	27. Manner of Death 1 X Natural 2 Accident 3 Suicide 4 Homicide

1 Yes 2 No

29a. Certifier

State Registrar

15

Hos	spital: 1 X Inpatient 2	ER/Outpatient	 з [] [OOA Other: 4 \(\sum_{\text{Nursi}} \)	ng H	ome 5 Residence 6 Other (Specify)
n	28a. Date of injury (Month, Day, Year)	28b. Time of injury	М	28c. Injury at work? 1 ☐ Yes 2 ☐ No		28d. Describe how injury occurred
oe	28e. Place of Injury - At he building, etc. (Specif		, facto	ry, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)

Investigatio 6 Could not b 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

D70241

29d. Date signed (Month, Day, Year) 12/16/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8600 Old Georgetown Road, Bethesda, Maryland 20817 Shanthi.

Nadar, Shanth 1. Date filed (Month, Day, Year) **DEC 2 0 2011**

5 Pending

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			. For	State of Maryland / De	epartment of Health and			10000		
			1 - State Registrar	C	Certificate of Death	Reg.	2011	42659		
п	Physici	an	Decedent's Name (First, Middle, Last	,	D	Date of Death Month	Day Year	3. Time of Death		
	/Medic	al		atava	Brightwell	December		1917 M		
	Examin	er	4a. Facility Name (If not institution, give	•	4b. City, Town, or Location of De	eath	4c. County of Deat			
	Funeral		5817 Folkstone Residual Security Number 6. Se		Bethesda Say		Montgome 9. Birt	hplace (State or Foreign		
в	Director		220-56-4060	□M 2 F 61 Yrs	Months Days Hours M	June 7,	950 Co	NC		
	pur		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	or Location			10d. Inside City Limits		
	Maryis	or						1 ☐ Yes 2 No		
	1 the 7 286	Director	MD Montgome 10e. Street and Number	ery Bethesd	La. 10f. Zip Code	10g.	Citizen of What Co	juntry?		
	hours after death with the Maryland turel', or Items 23e or 28e-1 show at Examinar must be notified at	al D	5817 Folkstone R	oad	20817	U	nited Sta	ates		
	ems	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)	14. Race - Ame Black, White			
36	s afte	by Fu	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 K No	1 ☐ Yes 2 No Specify:		,			
21215-0036	turei	10a. State 10b. County 10c. City, Town or Location						Gucasian Susiness/Industry		
215	within 72 ene. then "net	plet	(Specify only highest grad	de completed) (C	Give kind of work done during most of the DO NOT use retired)	working		Medicine		
2	filed withi Hygiene. other then ent, IDE M	Completed		4 Adm	inistrator's Assi			Library of		
and	ould be fill Mental H tarked oth	Be	17. Father's Name (First, Middle, Last)	_		Name (First, Middle, Maid	len Surname)			
Maryland	should ind Men in marke umatic	To	Elmer 19a. Informant's Name/Relationship (T)	Crow	71 Svatava Mailing Address (Street and Number or		hi or Tourn State	Hansa		
	nd 2:		David R. Brightw	1/1	7 Folkstone Drive					
Baltimore,	of Health of Health fitem 27		20a. Method of Disposition	20b. Place of Di	isposition (Name of crematory or other place)		. Location - City or			
Ē	permit. Pages Depirtment of Importent: If it any njury or o		1 ☐ Burial 2 X Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	removal from State		/17/2011 GI	len Burni	e, MD		
Salt	Depenti Depenti Importa any nj		21. Signature of Funeral Service Licens		22. Name and Address of Facility Thibadeau Mortua	rv Service.	p.a.			
	0.D ≒ e ol		for / ller	M00956	7 Park Avenue, G	Saithersburg	, MD 2087			
	Physician /Medical Examiner		23a. Page. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	lications that caused the death. Do not one cause on each line.	enter the mode of dying, such as card	diac or respiratory arrest,		Approximate Interval Between Onset and Death		
			disease or condition resulting in death)	a. METASTATIC BREA Due to (or as a consequence of):				4 MONTHS		
				PRIOR STAGE II B				2.5 YEARS		
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):						
	and and	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
/60,	ate be executed hysician and the burial-	cal E	75551111/9	Due to (or as a consequence of):						
289	ficate physis the			d						
Box	eath certificate attending phy I for use as the	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy	aCC		23d. Date of del	livery		
	death	by Physician/Med	in the past 12 months? 1 \(\sum \) Yes 2 \(\overline{\text{X}}\) No	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year		
J.	at the de d by the etached	Phys	9 Unknown							
က်	The law requires that the death certifica tte has been signed by the attending ph tage 2 should be detached for use as th		Part II. Other significant conditions co	ntributing to death but not resulting in th	ne underlying cause given in Part I.	23e. Did tobacc		the cause of death?		
Records,	w require been sig should b	Completed				24a. Was an				
Ř	: The law cate has	dmo				autopsy performed	? prior to death?	utopsy findings available completion of cause of		
Vital		യ	25. Was case referred to medical		26. Place of I	1 Yes 27	No 1 Yes	2 X No		
	nysici nis cer i direc	To B	examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa		g Home 5 🕅 Residence	6 ☐ Other (Spe	cify)		
0	ing Ph Mer thi		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Tim	ne of 28c. Injury at work?	28d. Describe how in	e how injury occurred			
120	Attendi death. ctor: A y the fu	icat	2 Accident investigation 3 Suicide 6 Could not be	29a Place of lains. At home form	M 1 Yes 2 No	29f Location (Street				
Division of	of or Attending P after death. I Director: After t d in by the funera	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	City or Town, S.	(Street and Number or Rural Route Number, own, State)			
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 X Certifying Phy	vsicien: To the best of my knowledge, d	death occurred at the time, date and pla	ace, and due to the cause	e(s) and manner as	s stated.		
	in 24 in 24 he Fu	Medical	(Check only 2 Medical Exami	iner: On the basis of examination and/o and manner stated.	or investigation, in my opinion, death o	ccurred at the time, date	and place, and due	e to the cause(s)		
		Σ	29b. Signature and title of certifier	. 11	29c. License number	29d.	Date signed (Mont	h, Day, Year)		
	10		- LUMA TOH	porturo	D37236	De	cember 1	6, 2011		
			30. Name and address if person who come lawn. Hondricks		pe, Print) Dr., #506, Bethes	ada MD				
	Sta	te	Carolyn Hendricks 31. Date filed (Month, Day, Year)	00.00.00.00		oud PID				
	Registr		OEC 2 0 201	32: Hegistrar's Signature	ares					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 Congetta G. Burke December 8:45 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Montgomery Arcola Health & Rehab. Center Silver Spring Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours (Month, Day, Year) 214-34-6887 **Director** 1 M 2 X F 96 Jan. 18, 1915 Washington, DC Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Montgomery Silver Spring 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral 10302 Castlehedge Terrace 20902 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Nas Deceden. _ Armed Forces? 1 ☐ Yes 2 🏝 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Pietro Genovere Rosina Tenaglia traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health at Important: If item 27 is any injury or other trat once. Thomas J. Burke, Jr./Son 10302 Castlehedge Terrace, Silver Spring, MD 20902 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Dec. 15, ort Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Lices 500 University Blvd. W., Silver Spring, MD 20901 23a. Part Effler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Possible Pneumonia Medical Due to (or as a consequence of): **Examiner** Lung Mass Sequentially list conditions Examine if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or). that initiated events resulting in death) Last Due to (or as a consequence of): physician Completed by Physician/Medical Box 68760 the l as IF FEMALE: detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant g Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CVA, Dementia, Failure to Thrive Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has autopsy 1 Yes 2 No 2X No Division of Vital the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 KXNo Other: 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) ie Hospital or Attending Pl n 24 hours after death. ie Funeral Director: After th 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 XNatural 1 Yes 2 No M Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier

State Registrar

within 2 To the F

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

SWOW

DEC 15 2011

30. Name and address of person who complete Rajan Shyamsundar, MD

oted cause of death (Item 23a) (Type, Print) 9801 Georgia Avenue, #117, Silver Spring, MD 20902

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

D53367

29d. Date signed (Month, Day, Year)

Dec. 12, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 08, 2011 Rolf J. Burke Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery Casey House 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) **Funeral Director** 216-20-9863 85 1 X M 2 D F July 06, 1926 Maryland ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location the Maryland Director 1 Yes 2 X No Chevy Chase Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with 20815 u.s.A 8100 Larry Place or items 12. Was Decedent Ever in U.S. Armed Forces?

1 🚨 Yes 2 🗌 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once. Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: 3 Widowed 4 Divorced Completed WWII White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Retail 4 Business Executive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Jacob Bercowitz Minna Tauber 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Hannah Burke - Spouse 8100 Larry Place, Chevy Chase, Maryland 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Judean Memorial Grdns 12/11/2011 4 Donation 5 Other (Specify) Olney, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licenses 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Lung Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) and that the death certificate be executed Due to (or as a consequence of) attending physician I for use as the burid Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Petal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Dav Year Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has be autopsy performe death? Yes 2 X No 1 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: $_4$ \square Nursing Home 5 \square Residence 6 [X] Other (Specify) Hospital: 2 X No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending work?
1 ☐ Yes 2 ☐ No 1 X Natural Investigation 6 Could not be Accident filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one EX Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signate R143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Road, Rockville, Maryland 20850 Debrah Miller. CRNP, 31. Date filed (Month, Day, Year) 2. Registrar's Sign State 5 Registrar

11-09268 Semen Buslovich Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Dhysisian	1- For State Registrar			Cen	tificate (of Deat	h			Reg	, No.	JI	1 4200
Physician/	1. Decedent's Na	me (First, Middle,L	ast)						Mo	te of Death nth	Day Yea	ır	3. Time of Death 0655 hrs
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	5. Social Security			e (In vrs. la	st birthday)		ler 1 Year	If Under 24	Hrs. 8. D	ate of Birth			hplace (State or
Funeral Director	217-33	-5532 ¹	XM 2 F 93			Month			41	1-28-	•		
any .	Usual Residence	of Decedent 10b. County		10c. City,	Town or Loc	ation					· ·		10d. Inside City Limits
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Maryland 28a-f show 1 at once. ector	MD . 10e. Street and I	Montgon Number	nery	Kens	ingeo	10f. Zip	Code			100	g. Citizen of Wh	nat Coun	try?
th the Maryland 23a or 28a-f sho notified at once, al Director	10920	Connectio	out Ave.			20	895			U	nited S	State	es
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Inst: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director			12. Was Decedent	?				anic Origin? Mexican, Pue				- Americ e, etc.	can Indian, Black,
iter de	3 Midowed	4 Divorc	ed If Yes, Give Yaar	X No	1	Yes 2	X No	specify:			Specify:	Whi	te
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Iankee	Buslovio Name/Relationship	ch		19h Mail	ina Addres	The State of the S	31uma (er, City or Tow	n. State.	Zip Code)
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Baltimore, M pernit. Pages 1 and 2 Department of Health Important: If item 2 injury or other trans			3 Removal from S		rematory or			Dark 1	2_12_	-2011	Rockvi	11e.	Maryland
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Balti permit. Departm Importa		Heelhu		579		170 F	Rocky				ville,		20852
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Division o To the Hospital or Attending Within 24 hours after death. To the Funeral Director: After the Completely filled in by the funeral Dartification:	29b. Signature a 30. Name and a Carol Alla	6 Could release	sician: To the best of riner: On the basis of example and manner stated the completed cause of stant Medical Example in the completed cause of stant Medical Example in the completed cause of stant Medical Example in the complete in the co	ny knowledgamination a l. L death (Item	ge, death od nd/or investi	gation, in m	O.C.M	death occurrence number	Newp and due to ed at the t	oort Mill R o the cause time, date a	d at Lawrence e(s) and manne and place, and of 29d. Date sign	er as state due to th	ed. e cause(s) nth, Day,Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 42663 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 12, 2011 Physician/ 1350 Ta' Laiya Renee Brooks Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Silver Spring Holy Cross Hospital Montgomery Age (In yrs. last birthday) Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Hours Min Country None Director 1 M 2 X F Yrs 18 12/12/2011 Maryland 28a-f show 10a State 10b. County 10c City Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 X No Seat Pleasant Maryland Prince George's o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 6300 Field Street 20743 U.S.A items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🔯 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. ō 1 X Never Married 2 Married þ African-American Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural". Completed 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) uld be filed within 7 Mental Hygiene. College (1-4 or 5+) None None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pierre Tyrone Brooks Tiffany Renee Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 9113 Hobart Street. Springdale. Pierre Tyrone Brooks - Father Maryland 20774 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or oth 1 Burial 2 X Cremation 3 Removal from State Ft. Lincoln Crematory 12/22/2011 | Brentwood, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 1232 11800 New Hampshire Ave., Silver Spring, MD 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition Prematurity Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): 1 certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical P.O. Box 68760 the attending plants IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 2 X No 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown Completed peen Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe page 2 certificate 1 Yes 2 No 1 ☐ Yes 2 🗶 No rector, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🗓 No ٥ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After tompletely filled in by the funer. To the Hospital or Attending X Natural 5 Pending work?
1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year) DEC 19 2011

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thaddeus Ivory Lancaster, M.D., 1500 Forest Glen Road, Silver Spring, MD 20910 32 Registrar's Signature

90064410

12/2/11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 7 1:18p M Ruth Elizabeth Jones Bell 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bowie Health Center Prince George's Bowie Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days Min. (Month, Day, Year) 229-42-0731 **Director** 88 1 M 2 X F 09/24/1923 Virginia 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 X No Maryland | Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, <u>the Medical Ex</u>aminer must be I Funeral 13101 Old Fletchertown Road 20720 u.s.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify Specify: 3 Widowed 4 X Divorced Black Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) of Health and Mental Hygien of Health and Mental Hygien fitem 27 is marked other th 5+ Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Robert Ellsworth Jones Inez Alexander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Olivia Bell - Daughter 3523 Ellerton Road, Bowie, Maryland 20716 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Washington Natl. Cem. 12/13/2011 Suitland, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licens monate 11800 New Hampshire Ave., Silver Spring. MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 3 days Acute Gastrointestina disease or condition Medical resulting in death) Examiner Respiratory years hronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events southing to death). Due to (or as a consequence of buria ur To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and erebrovascula years resulting in death) Last Physician/Medical Box 68760 the IF FEMALE use yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown been signed by the atter should be detached for Month Day Year Pregnant at time of death Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 💢 lo 3 🗌 Probably 4 🗌 Unknown Coronary Artery Disease Completed 24b. Were autopsy findings available prior to completion of cause of death? Chronic Atrial Fibrillation 24a. Was an autopsy perform 1 Yes 2 No Yes 2 completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No. 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 28b. Time of injury 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural Accident Investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 12-8-2011 D0012015 30. Name and address of person who completed ause of death (Item 23a) (Type, Print)

Registrar

State

Steinber

31. Date filed (Month, Day, Year)

DEC

6492

1.0

Landova Rd, Cheverly, MD 20785

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. Amend 21 per FH 6923 1/11/1/2 dk
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month John Donald Bushby, Sr. 12 12:25 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Brighton Gardens Columbia Howard 9. Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min. 213-09-6572 97 11-18-1914 Director NJ Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 28a-f must be notified MD Howard Columbia 1 Yes 2 No 'n 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 7110 Minstrel Way 21045 United States items 12. Was Decedent Ever in U.S. Armed Forces?

1 ♣ Yes 2 ☐ No
If Yes, Give 1952- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Examiner Black, White, etc. 10 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Year or Dates. 1952–54 Specify: White "natural" Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. the Mec Elementary/Seconday (0-12) College (1-4 or 5+) Civil Engineer Engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lulu G. Woodworth Gilbert Haven Bushby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John D. Bushby, Jr./son 6242 Meadowcroft Rd Eldersburg, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 urial 2 🗌 Cremation 3 🗎 Removal from State 12-21-11 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee <u>Andre Amato per DVR</u> 4112 Old Columbia Pike Ellicott City MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MER DISEASE Physician/ 21 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of): as the burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 attending IF FEMALE for use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) signed by the a Id be detached f a 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? Completed by the Hospital or Attending Physician: The law requires thin 24 hours after death.
The Funeral Director: After this certificate has been sign upleted filled in by the funeral director, page 2 should be 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Yes 2 No 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? injury 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the I

complete 3 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) m.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) # HARAY N 00 DW **Pagistrar's Signature** State white Registrar

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 2011 December 0135 Brumbaugh Marie Donna Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Memorial Hospital at Eastor Easton 00 If Under 1 Year | If Under 24 Hrs. | Hours | Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 45 156-60-8702 Director 1 M 2 XF 1-20-1966 New Jersey Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location Director 1X Yes 2 No DE Dover Kent 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ortant: If item 27 is marked other than "natural", or items 23a o injury or other traumatic event, the Medical Examiner must be Funeral 19901 99 Sorghum Mill Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. by 1 Never Married 2 Married Yes 2**X** No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Owned home should be filed with and Mental Hygien 7 is marked other th 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Caroline McCaffrey Edwin Bonham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau 99 Sorghum Mill Rd., Dover, DE 19901 Craig Brumbaugh/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Summit Cremation Services, LLC 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/21/11 Wyoming, Delaware 21. Signature of Funeral Service Licensee 4 22. Name and Address of Facility Pippin Funeral Home, 19934 -119 W. Cam-Wyo Ave. Wyoming, DE ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition hour Medical resulting in death) Examiner Unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last and attending physician for use as the buria Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has death?
1 Yes 2 No Hospital or Attending Physician: The 24 hours after death.

Funeral Director: After this certificate Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural iniury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 within 2 To the I only one 29b. Signa 29c. License number 29d. Date signed (Month. Day, Year D0060060 MP 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Emergency Department DAVID C. WHITE MD Hospital, 219 5. Wash Easton Memorica,

DHMH 17 Rev 06-2011

Registrar

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NNA

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32. Registrar's Signature

DEC 21 2011

219 S. Washington

Please Type or Print in Black Indelible Ink, Frayer Alk Copies Are Legible.
Amend 27 per med cert G923 1 723 4 Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Marcella Heiser ไล 20ปีใ Edith Brackney December 1555 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Caroline Nursing Home Denton Caroline 5. Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Days Min. Ohio Country) Hours July 20 1916 95 Director 275-05-5771 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Caroline Greensboro 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? Funeral 26040 Fox Grape Road 21639 USA 'natural", or items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 📉 No Black, White, etc. ģ 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor: customer service publishing industry marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Carl Heiser Cora Aretta McQuay permit. Page 1 and 2 shoul Department of Health and I Important: If item 27 is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marcella Magill/ daughter 26040 Fox Grape Road; Greensboro, Maryland 21639 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Miami Valley Mem Gard Dec 29 2011 Dayton, Ohio Signatur of Funeral Service Licenses 22. Name and Address of Facility PO Box 160; Greensboro, MD 21639 Fleegle and Helfenbein Fune 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Fleegle and Helfenbein Funeral Home, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ ndomem disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of): requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 mooths?

1 Yes 2 No
9 Unknown Dav Pregnant at time of death 9 Unknown Division of Vital Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation within 24 hours after death

To the Funeral Director;
completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one ature and title of certifier 29d. Date signed (Month, Day, Year) 00053255 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) notes & Streeton Butler 3683 C 31. Date filed (Month, Day, Year)

188

DHMH 17 Rev 7/2009

State

Registrar

DEC 2 2 201

32. Registrar's Signature

11-08773

Amend 28c per OCME 1/6/12/dk	
Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible.
State of Maryland / Department of He	ealth and Mental Hygiene

James Jesse Bullock 2011 42668 1. For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day November 21, 2011 1457 hrs Medical Examiner James Jesse Bullock 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Cecil Rt. 213 @ Locust Point Road Elkton 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year If Under 24Hrs. **Funeral** oreian Months Days Hours Director 05/10/1987 Country) Delaware 24 216-23-8306 1 X M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 1 Yes 2 X No show E1kton Maryland Ceci1 within 72 hours after death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21921 United States 343 East Village Road 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married 1 X Yes 2 5 or Dates: 2007—present 1 Yes 2 X No specify: Specify: White 3 Widowed 4 Divorced 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) ltimore, MD 21215-0036 2 Aviation Airplane Mechanic permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Velvet Jane Schneiders James M. Bullock 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) ဥ Velvet Schneiders/Mother 248 Brick Hill Road, Elkton, Maryland 21921 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) November 1 Burial 2 X Cremation 3 Removal from State R.A. Ferris & Co., Inc. 23, 2011 West Chester, PA 4 Donation 5 Other Specify. njury or 21. Signature of Funeral Service Licens 22. Name and Address of Facility Hicks Home for Funerals. P.A. Stockton St., Elkton, MD Approximate Interval ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician \/Medical 23a Part I. Enter the disease, or complication Between Onset and failure. List only one cause on each line Death a. Multiple Injuries Immediate Cause (Final disease Èxaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause, Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): this certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial - transi Physician/Medical AMENDED UNPENDED Box 68760, 23d. Date of delivery IE EEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 2 Fetal death Live birth 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? 1 🗸 Yes ✓ Yes 2 No 2 No 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi 25. Was case referred to medical of Vital Be Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 DOA 1 Yes ٩ funeral 28a. Date of Injury FOUND: 8c Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death Passenger in an auto to auto collision Certification: Natural FOUND 1 Yes 2 No Division Pending the Nov 21, 2011 1457 hrs Investigation 2 🗸 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) Rt. 213 @ Locust Point Road, Chesapeake City, MD determined (Specify) Major Road / Highway 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number November 22, 2011 O.C.M.E. Jumet Towhelf, MI 30. Name and address/of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Pamela E. Southall, MD 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State IAN O 6 Registrar

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month December 2011 РМ Susie Elizabeth Cline 1750 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Laurelwood Care Center Cecil Elkton Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 9. Birthplace (State or Foreign Funeral Days Hours Min 1 M 2 7 F Months Virginia 90 **Director** 253-32-0343 T921 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland notified at 10d. Inside City Limits Director 1 🗓 Yes 2 □ No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral 226 Hollingsworth Manor 21921 United States permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Cafeteria Assistant Board of Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Grubb Birdie Ross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth E. Cline/Son 1332 Leeds Road, Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Gilpin Manor Memorial Park 1 X Burial 2 Cremation 3 Removal from State December 4 Donation 5 Other (Specify) 28. 2011 Hicks Home for Funerals, re of Funeral Service Licensee 21. Signat 22. Name and Address of Facility 103 W. Stockton Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine the bunial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: es, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Year 5 Other (specify) Month Pregnant at time of death Day been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has h autopsy performed? Yes 2 No page 2 certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 ☑ No Hospital မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one . 29c. License numbe 29d, Date signed (Month, Day, Year)

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sachde

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42570 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 24 2611 Physician/ Month Carroll Clabaugh J. 12:20 A M December Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Meritus Center lagerstown Medical Year If Under 24 Hrs. 8. Date of Birth
Days Hours Min. 08 08 1930 Numbe Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months 8i 217-28-5867 Middleburg, MD Director Usual Residence of Decedent 28a-f show iral", or items 23a or 28a-f shor Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rector Antrim Township PA Franklin 1 🗌 Yes 2 🔀 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17225 14275 Penn Dixie Lane IIS 12. Was Decedent Ever in U.S. Armed Forces? 1 May Yes 2 Mo If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc by 1 Never Married 2 X Married hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white "natural", Completed 3 Widowed 4 Divorced Specify Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 72 ith and Mental Hygiene.
27 is marked other than 'traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) the manufacturing co. machinist 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important: If item 27 is marked to any injury or other traument: Clarence Joseph Clabaugh Edna Griffin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 14275 Penn Dixie Lane Greencastle, PA 17225 Shirley A. Shry Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 12/29/2011 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Chambersburg, PA 4 Donation 5 Deher (Specify) Parklawn Memorial Gar**d.** 21. Signature of Funeral Service Licensee Miller-Bowersox Funeral Home, Inc. 22. Name and Address of Facility Greencastle, PA Washington St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph ician disease or condition resulting in death) Medical **Examiner** 10 condu 24 hour Sequentially list conditions. ner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

The Funeral Director: After this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burial-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death Month Year 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform death? 1 ☐ Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 20 No Hospital Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) . Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No М Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) within 24 hours a

To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAM 368 nue strat JAN 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 14,2011 Physician/ June Eslin Chick 11:00aM December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Brooke Grove Nursing Home Sandy Spring Montgomery 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) If Under **Funeral** Hours 82 579-30-1170 Director 1 □ M 2 🎗 F April 30,1929 Washington, DC Usual Residence of Decedent or 28a-f show 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director Sandy Spring Maryland Montgomery 1 ☐ Yes 2 🗓 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20860 u.s.A. 1639 Hickory Knolls, Room 13 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify 3 ¥ Widowed 4 ☐ Divorced Caucasian Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) artment of Health and Mental Hygiene, ortant: If item 27 is marked other than "injury or other traumatic event, the Mec Elementary/Secondary (0-12) College (1-4 or 5+) Education Library Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Mary Grace George Eslin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health at Important: If item 27 is any injury or other trau 17813 Overwood Drive, Olney, Maryland 20832 Donald Eslin Chick - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) St. George Cemetery 12/19/2011 Valley Lee, Maryland . Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death 10 Years Immediate Cause (Final Physician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) and that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 the attending p IE EEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 X No Month Day Year Pregnant at time of death ed by the a 9 Unknown Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed to Completed by 1 Yes 2 X No 3 Probably 4 Unknown Records. been signated 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an his certificate has b Il director, page 2 sl performed? Yes 2 X No or Attending Physician: The 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Division of Vital Be Hospital: 2 X No Other: ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) this To the Funeral Director; After this completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Yes __ Accident Investigation within 24 hours after deatl To the Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical 1 🙀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 🗆 only one)

Registrar

12

31. Date filed (Month, Day, Year) DEC 1 6 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signayura and title of certifier

George Sengstack, M.D., 3929 Ferrara Drive, Wheaton, Maryland 20906 32 Registrar's Signature

D0012121

29d. Date signed (Month, Day, Year)

December 15, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 13, 2011 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** Regional Prince George's Hospita _aurel _aure 9. Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days 1 🎇 M 2 🗆 F 05/04/1921 214-16-7946 Director 90 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shovamy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No Beltsville MD Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20705 5516 Odell Road 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 19
If Yes, Give 10 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1942-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black 3 X Widowed 4 ☐ Divorced 1945 Year or Dates 16a Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Transportation Dept. Elementary/Seconday (0-12) College (1-4 or 5+) Ft. Meade Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Helena Matilda Matthews Samuel Isreal Crump 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5516 Odell Road, Beltsville, MD 20705 Beverly T. Hudson/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington Nat'l Cem | 01/03/2012 4 Donation 5 Other (Specify) Arlington, VA 21. Signature f Funeral Service 22. Name and Address of Facility Snowden Funeral Home each 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Malnutri Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** neumonia Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury physician and the burial transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Decubitus Stage III Peripheral 2 No 3 Probably 4 Unknown Cholangitis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No page 2 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital မ | X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No injury Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number D 0066284 29d. Date signed (Month, Day, Year) nd address of person who completed cause of death (Item 23a) (Type, Print) 7300 Van Dusen Road

State Registrar

DHMH 17 Rev 7/2009

Malik,

1 9 2011

Date filed (Month, Day, Year)

DEC

MD

Laurel

2. Registrar's Signature

Regional Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Physician/ 15° DEC 2011 7:28 Рм LILY BREN COUCH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY WRNMMC BETHESD*E* If Under 1 Year If Under 2 8. Date of Birth Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2 T F Days (Month, Day, Year) Country) Director none Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "nature." 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2X No MD Rockville Montgamery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20852 198 Halpine Road, #1405 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1X Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) none Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sheri Hyder Walter Joe Couch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 198 Halpine Road, #1405, Rockville, MD 20852 Walter J. Couch/father 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State rdent Cremation Sv 12/19/2011 4 ☐ Donation 5 ☐ Other (Specify) Hanover, MD 21. Signature 1 Funeral Service Lice 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ EXTREME PREMATURITY disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events at this indicated to the cause of the cause Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Pregnant at time of death Month Day Year 5 Other (specify) Yes 2X No g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 💢 No 1 🔯 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA မ 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Accident 5 Pending iniury 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 He Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier 2 Underlical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioners to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature nd title o 29c. License number 2011 MD D65419 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WRNMMC, BETHESDA, MD 20889 5600 AGNES N SIEROCKA LTC MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State

Registrar

201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registra/MEND#28fperIME, 12/20/11; BW, MCCO

Registra/MEND#2/perIME, 12/20/11; BW, MCCO

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Stanley Sheppard Cohen 12:00p M December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday Funeral If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) New York 1**X** M 2 □ F Months 01/28/1924 Director 078-18-1341 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Maryland Bethesda 1 Yes 2 X No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7208 Millwood Road 20817 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☑ Yes 2 ☐ No 1943-Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: "natural", 3 🗌 Widowed 4 🗌 Divorced Completed Specify 1954 Year or Dates White other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Dentist Dentistry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Irving Cohen Minnie Weinstein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>s</u> and 2 s Health t Jau Cohen - Son 3606 Spring Street, Chevy Chase, Maryland 20815 item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important; If ite any injury or ot 1 X Burial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King David Mem Grdns | 12/12/2011 | Falls Church, Virginia 21. Signature of Funeral Service Licenser 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, oly one cause on each line. 23a, Part 1. Enter the dise Approximate Interval Between Onset and Death shock, or heart failure. Lis Immediate Cause (Final Physician Cerebral Hemorrhage disease or condition $\Delta W \Delta$ Medical resulting in death) Examiner 3 Ruptured Cerebrat Vessel Hours Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Examine Due to for as a consequence of Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension Completed 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an page 2 autoosy prior to completion of cause of performed? Yes 2 X No death? 1 Yes 2 No or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital: 2 🗶 No Other: 1 X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 2 X Accident 2 No Dec & 2011 Investigation 1700 M within 24 h urs after deal To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and N7208 r RM Industrial WOOD, Rd completed filled in by 4 - Homicide Home Betherna Hospital Medical 29a Certifier 1 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 10+1 MD 68374 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Don Shields, M.D., PhD.8600 Old Georgetown Road, Bethesda, Maryland 20851 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra AMEND#8per INF, 12/29/11; BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month/10/2011 Physician/ MARGARET CATHERINE COATES 9:10 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Ft. Washington Ft. Washington Hospital 8. Date of Birth (M21), Day, Year) 6/23/1927 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral Director** 247-36-8849 1 M 2 D SC 84 Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits 10a. State notified at Director 1 X Yes 2 No 28a-f DC Washington, DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or mortant: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a one. Funeral U.S.A 20017 1328 Girard St. NE Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. 1 Never Married 2 Married ģ Yes 2X No Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. If Yes, Give Specify: **Black** 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Medical Nurses Aide 12th Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) မ Catherine Foster Faye Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1328 Girard St. NE, Washington, DC 20017 Donald Coates/son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 12/19/2011 Boyds, MD Marks Cemetery 4 ☐ Donation 5 ☐ Other (Specify) St. permit. 22. Name and Address of Facility Snowden_Funeral Home, P.A 21. Signature of Funeral Service Licens Leva 246 N. Washington St., Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Bilateral Precumenia Onset and Death Ferler Immediate Cause (Final with Ressiahin Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Due to for as a consequence on an and the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ed by the attending physician detached for use as the buris Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown cate has been signed by the ; page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Renal 2 ⊮No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed?

1 Yes 2 No death? 1 ☐ Yes 2 ☑ No within 24 hours after death.

To the Funeral Director: After this certificate pletely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Medical Certificate: work? 1 ☐ Yes 2 ☐ No injury Natural 5 Pending Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

State Registrar

1

29a. Certifie

(Check only one)

29b. Signature and the of certifier

Mmu

Richard Palmer MD

31. Date filed (Month, Day, Year) **DEC 15 2011**

Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0055120

Southern avenue SE Suite 310 Washington De

29d. Date signed (Month, Day, Year)

December

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 12, 2011 Joseph Matthew 7:50 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Haven Assisted Living Montgomery Chevy Chase If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) 235-28-3930 1 XXM 2 - F Director 88 Feb. 3, 1923 WV Usual Residence of Decedent show 0a. State 10b County 10c. City. Town or Location 10d. Inside City Limits the Maryland Director notified 1 🗌 Yes 2 🌁 No 28a-1 MD Chevy Chase Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ō must be 23a Funeral with 8600 Jones Mill Road 20815 USA items death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner or þ 1 Never Married 2 Married Specify: White within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural", 3 X Widowed 4 ☐ Divorced Completed Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Bill Collector Self-Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental F fitem 27 is marked o r other traumatic eve ည Raymond Basil Cox Georgianna Lee Bowers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a Sharon C. Spivey/Daughter 8321 Cooper Street, Alexandria, VA 22309 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Important: If it any injury or conce. 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State $^{\mathrm{Dec}}_{\mathrm{2011}}$ Gate of Heaven Cemetery Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Francis J. Collins Funeral Home Inc 500 University Blvd. W., Silver Sp. Silver_Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Providence Ventricular Fibrillation disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year the s signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed been : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 s has To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 2 🗆 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 K No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1XXNatural 5 Pending Investigation Accident filled in by the 6 Could not be Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Mysician: To the Medical Examiner: On the 29a. Certifier best of my knowledge, death courred at the time, date and place, and due to the cause(s) and manner as stated. pation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. The leath occurred at the time, date and place, and due to the cause(s) and manner as stated. sis of examination and/or inves luise Practitioner: To the best of my knowledge only one 3 Certifying I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 H51280 Dec. 13, 2011 30. Name and address of person who completed cause of death (Item 23a

State Registrar

DHMH 17 Rev 06-2011

Anushiravan Dadgar,

OEC 15 2011

MD

32 Registrar's Signatu

10110 Molecular Drive, Rockville, MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 42677 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBER Suzanna Kay CUDDY Year 2011 1002 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Meritus Medical Center Hagerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🗓 F 216-54-8519 october 5,1949 Maryland 62 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Hagerstown 1X□ Yes 2 □ No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral 11 West Baltimore Street 21740 U.S.A. items ; hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 0 þ 1 Never Married 2 X Married Maryland 21215-0036 "natural", 1 Yes 2 No Specify: white Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene tant: If item 27 is marked other than 'iury or other traumatic event, the Me iury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 none none Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Marvin Hasenbuhler Helen Bloyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
60 Flagstaff Circle, Martinsburg, West Virginia 25405 Department of Health ar Important: If item 27 is any injury or other trauonce. Jennifer Galipo - daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 🔀 Cremation 3 🗆 Removal from State December 11 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland Hagerstown Crematory Signature of Funeral Service License Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ evere disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any least sequentially list cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 1 Live Birth
4 Pregnant
9 Unknown in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? this certificate death? 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural 5 \square Pending injury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Cify or Town, State) Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier соmpleted 3 🗆 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

TIU-5

29b. Signature and title of certifier

East

31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARD KODUAH

Antietam St., #306, Hager

D0069606

Stown

DECEMBER 23

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of Maryland / Department of Health and Mental Hygiene								
		_1	State Registrar AMENDED #7 PER FUNERAL HOME Ce	rtificate of Death _{CCHD}	AS 12/29/1	42011, 42678			
	Physicia		1. Decedent's Name (First, Middle, Last) Betty Mae Chance			3. Time of Death 3. 2011 8:20 A			
	Medic Examin	_	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death			
	LXammi	Ğ.	520 Kerr Avenue	Denton	10.1	Caroline			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	(Month, Day, Year)	Country			
	Director		216-40-4283 1 M 2 XF 78 Yrs. Usual Residence of Decedent		Aug. 5,	925 Maryland			
	show dat	l. h	10a. State 10b. County 10c. City, Town or Lo			10d. Inside City Limits			
	Mary 28a-f otifie	irec	MD Caroline	Denton	Tag.	Y⊆ Yes 2 No			
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural" or item at be notified at other traumatic event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 520 Kerr Avenue	10f. Zip Code 21629		Citizen of What Country?			
	eath w	-une	11 Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - American Indian,			
36	fter de ", or if amine	by	1 Never Married 2 Married Armed Forces? 1 Yes 2 No If Yes, Give	1 ☐ Yes 2 ▼No Specify:	o riioari, oto.j	Black, White, etc. Specify: White			
<u>ö</u>	ours a atural cal Ex	Completed	3 ☑ Widowed 4 □ Divorced Year or Dates. 15. Decedent's Education 16a. Dece	dent's Usual Occupation	16b.	Kind of Business Industry			
215	an "na Media	g.	(Specify only highest grade completed) (Give	kind of work done during most of wo. OO NOT use retired)	rking				
21	withir giene ner th t, the		10 Home	maker		Own Home			
and	be filed ental Hy rked oth ic event	To Be	17. Father's Name (First, Middle, Last) Clinton Leonard Willey	1	me <i>(First, Middle, Maide</i> os Elizabe				
ız	should be file and Mental I is marked o raumatic eve			Frances Elizabeth Hicks lling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
N	and 2 sh Health ar tem 27 is	П				reston, MD 21655			
ore,	of He of He if item ir othe		20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cernetery, cre	matory or other place)		Location - City or Town, State			
Baltimore, Maryland 21215-0036	Page tment tant: jury o		4 ☐ Donation 5 ☐ Other (Specify) Hillcre			deralsburg, MD			
Bal	permit. Page 1 a Department of the Important: If ite any injury or ot				ramptom Fun 21632	eral Home, P.A.			
		П	23a. Part 1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.		c or respiratory arrest,	Approximate Interval Between Onset and Death			
	hat the death certificate be executed Table Medium Table by the attending physician and detached for use as the burial-transit Table and the death of the deat		Immediate Cause (Final disease or condition	e heart la	trailure u				
and a			resulting in death) Due to (a consequence of):	* 10.00 m					
		Jer	Sequentially list conditions, if any, leading to immediate	Cuerto (or as a nomical/ince of):					
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		al Ex	resulting in death) Last Due to (or as a consequence of):						
09,	ate be physic the bu	Physician/Medical	d						
687	certific nding	n/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	☐ Ectopic pregnancy		23d. Date of delivery			
Box 68760	death certificat ne attending ph ed for use as tf	sicia	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month Day Year			
P.O. I	that the cined by the detache		g Unknown Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?			
	+- C 0	d by	Quertia Pu	euman so	1 ☐ Yes	2 No 3 Probably 4 Unknown			
ord	requi been should	lete	AFRICO (Fibrillatio-	\mathcal{O}	24a. Was an	24b. Were autopsy findings available prior to completion of cause of			
3ec	The law ate has page 2:	Completed	CONQUALY ARTEN &	iscase	autopsy performed	? death?			
la	ysician: The is certificate director, pag	Be C	25. Was case referred to medical examiner?	26. Place of Death (Ch	eck only one)				
of Vital Records,	Physic this or	မ	1		Home 5 Residence				
0 0	ding Ith.	cate	1 Natural 5 □ Pending (Month, Day, Year) injury 2 □ Accident Investigation	work? M 1 Yes 2 No	2001 200011101 1101	,, ·			
Division	r Atter ter dea rector	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, Str	and Number or Rural Route Number, ate)			
ğ	oital o		2ga, Certifier 1 Certifying Physician: To the best of my knowledge, deat	a coursed at the time, date and place	and due to the cause(s)	and manner as stated.			
	To the Hospital or Attending Physician: The law requires within 24 hours after death. To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat (Check 2 Medical Examiner: On the basis of examination and/or inv only one) 3 Certifying Nurse Practioner: To the best of my knowledge	estigation in my opinion, death occurred	d at the time, date and pla	ace, and due to the cause(s) and manner stated.			
	Vithir Comp	2	29b. Signature and title of certifier	29c, License number		Date signed (Month, Day, Year)			
			James (3000)	103131	0 10	h 0/-//			
			30. Name and address of person who completed cause of death (Item-23a) (Type	ve Denti	ON MI	221629			
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	barre .	7				
	Registi	ar	OLU NIGLOTT	1000000					

DHMH 17 Rev 7/2009

By

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 4:45 Elnora Elaine Dechico 201 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Meritus Medical Center Hagerstown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Months Days Hours Min. 3/14/195 Florida **Director** 264-96-1668 60 Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Hagerstown MD Washington 10e. Street and Number 10f. Zip Code ems 23a or r must be r ö 10g. Citizen of What Country? Funeral USA 21740 278 South Prospect Street items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian. the Medical Examiner Yes, specify Cuban, Mexican, Puerto Rican. etc. Armed Forces?
1 ☐ Yes 2 ■ No Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes Give "natural", 3 Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Health Care Caregiver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Gladys Miller Floyd Holland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Belinda Holland / Sister 278 South Prospect Street, Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔲 Burial 2 KCremation 3 🗆 Removal from State Smithsburg Crematory 12/28/2011 4 Donation 5 Other (Specify) Smithsburg, Maryland 22. Name and Address of Facility Rest Haven Funeral Chapel Pennsylvania Ave., Hagerstown, MD 601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ 3 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, i.e. ing to immediate cause. Enter Underlying Cause (Disease or iinjury Due to or as a consequence of Exami attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month 4 Pregnant 9 Unknown Day Pregnant at time of death signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\sum \) Yes \(2 \sum \) No 24a. Was an page 2 autopsy has PULMONARI 1 Yes 2 No this certificate 25. Was case referred to medica examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 9 Hospital: 2 No 1 Tes 1 🗖 Inpatient 2 🔲 ER/Outpatient 3 🔲 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d, Describe how injury occurred After injury 5 Pending 1 Natural work?
1 \(\subseteq \text{Yes} \quad 2 \subseteq \text{No} \) To the Hospital or Attendii within 24 hours after death. To the Funeral Director: At completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying flurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one natu 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month.

Medical Compus Rd

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

21742

11-09595

Please Type or Print in Black Indelible Ink Figure All Copies Are Legible

i-09595 inda Sue Diano	,		e of Maryland									o :	1 1000
maa oac blane		I- For State	or waryland	•	ificate of		unu				g. No. 21	JI	1 4268
Physicia		Registrar 1. Decedent's Name (First, Middle,L	ast)						2	. Date of Death	1	-	3. Time of Death
ledical Examin		Linda Sue Diano					Month December					0019 hrs	
and a		4a. Facility Name (if not institution, g				4b. City, Tov Catons		cation of [Death		4c. County of Baltimore		
		1045 Maiden Choice Lar		e (In yrs. las	at histholous	If Under		If Under 2	24Hre	8 Date of Birth			hplace (State or
Funeral Director		212 66 0011		57		Months	Days	Hours	Min.	08/12/		Foreig	Maryland
J.1.00to.	ŀ	Usual Residence of Decedent	M 2XF		Yrs	•				00/12/	1,551		,
any	ŀ	10a. State 10b. County			Town or Locat	ion							10d. Inside City Limits
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Maryland 28a-f show	Director	10e. Street and Number				10f. Zip C				10	g. Citizen of Wh	nat Cour	ntry?
5 72 hours after death with the Maryland 11 "natural", or items 23a or 28a-f sho		1334 Huntover D	rive			211					USA		
h with	Funeral	11. Marital Status	12. Was Decedent Armed Forces?			s Decedent es, specify				cify Yes or No- ican, etc.)	14. Race White		can Indian, Black,
	튑	1 Never Married 2 Marri	1 Yes 2	X No		Yes 2					Specify:	Wł	nite
rs afte	<u>ā</u>	3 Widowed 4 X Divorce 15. Decedent's Education (Specify	ed If Yas, Give Year or Dates:	npleted)	16a. Deceder				nd of wo	rk done	16b. Kind of Bu	siness/	ndustry
2 hour	B	Elementary/Secondary (0-12)	College (1-4 or	7	during m	ost of worki	ng life. D				***		
within 72 giene.	Completed	12			Hor	memake	er				Home		
15-00 illed with Hygiene d other		17. Father's Name (First, Middle, La							•		laiden Surname)	
2121; uld be fil Mental F marked c event, i	B	Willard L. Ashk			Taok Mailia			Ella			ber, City or Tow	n State	Zin Codo)
MD 21215-0036 d 2 should be filed within 7 th and Mental Fygeiene. n 27 is marked other than numatic event, the Medica	٩	19a. Informant's Name/Relationship Melissa Houck									MD 211		, Zip Code)
	ŀ	20a. Method of Disposition			lace of Dispos	sition (Name	of ceme	tery,		Date	20c. Location -		Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 X Burial 2 Cremation		ete Mea	rematory or ot COWTIC	her place) ge_Men	noria	al [ec.	30 , 011	Elkrid	lge,	MD
Itimen ry or o		4 Donation 5 Other Spec 21. Signature of Funeral Service Lice	ify: ensee		22.1	Park Name and A					ma Dar	ole IP	uneral Home
Depa Impa					Ba 49	rranco 5 Rito	chie	sons, Hwy,	P.	A. Seve	erna Par	k,	MD 21146
Physician		23a. Part I. Enter the disease, or co- failure. List only one cause on	mplications that caused	the death.	Do not enter t	he mode of	dying, su	uch as car	diac or r	respiratory arre	st, shock, or he	art	Approximate Interval Between Onset and
/Medical Examiner			a.Alcohol an	d Dia:	zepam :	Intoxi	cati	ion a	ınd	cocaine	use		Death
£AaiiiiiGi		or condition resulting in death)	Due to (or as a conse	equence of)):								
	<u>_</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cons	equence of)):								
	튙	cause. Enter Underlying Causa (Disease or injury that initiated	С										
nsit ed	Examiner	events resulting in death) Last	Due to (or as a consid.	equence of)) :								
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cath certificate be eath certificate be a rattending physicia for use as the buria	Ped	IF FEMALE:	23c. If yes, outcor	-11				-		- 7	23d. Date of	deliver	,
587 ertifica fing p	a Z	23b. Was decedent pregnant in the past 12 months?	1 Live birth	None of dea		etal death		Ectopic p	oregnan	су	Month	ı	Day Year
Box 68760, e death certificate be the attending physiced for use as the bur	Physician/Med	1 Yes 2 V No 9 Unkno	7	ume or dea	5 O	ther (Specif	y)				1		
he the d		Part II. Other significant condition		h but not re	sulting in the	underlying c	ause giv	en in Part	I.	23e. Did to	bacco use contr	ibute to	the cause of death?
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the safer death. al Director After this certificate has been signed by led it by the funeral director, page 2 should be detacted.	ρ									1 Yes	2 🗸 No 3	Prol	bably 4 Unknown
cords, P law requires the has been signe	Completed									24a. Was a			topsy findings available completion of cause of
BCO ne law te has ge 2 s	鬞		· · · ·							perfor		death?	es 2 No
tal Reco		25. Was case referred to medical	2			26	.Place o	f Death (C	heck or	nly one)			
of Vital Recing Physician: The After this certificate funeral director, page	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie	ent 2	ER/Outpatien		<u>^ </u>				Residence 6		r: Scene
Of ing Pt After uneral		27. Manner of Death 1 Natural 5 Pandin	28a. Date of Inju (Month, Day,		28b. Time of	Injury 28		at Work?	- 1		now injury occum		ol and drugs
Sion strend death. ctor y the f	atic	2 X Accident S Pending	nation Id IZ-Z		unknow			s 2 X N					
Division pital or Atten ours after deat neral Director filled i by the	Certification:	3 Suicide 6 Could r			me, farm, stre	et, factory, o	office bui	ilaing, etc.		or Town, S	tate) 1045 1 Altimor	Maic	ral Route Number, City en Choice
Ospita hours uneral ly fille		29a. Certifier	sician: To the best of m	alley	e death occu	rred at the t	ime date	and plac					
Div To the Hospital o within 24 hours af To the Funeral D completely filled i	Medical	(Check only one) 2 Medical Exami	ner:On the basis of exa	mination an	nd/or investiga	ition, in my o	pinion, o	death occu	urred at	the time, date	and place, and	due to th	ne cause(s)
To To com	Mec	29b. Signature and title of certifier	and manner stated.			29c.	License	number			29d. Date sign	ied (Mc	nth, Day, Year)
		D_10-					O.C.M	l.E.			December	22, 2	011
		30. Name and address of person wi	no completed cause of	death (Item									
		Donna M. Vincenti, MD	Assistant Medi		niner 900	W. Balti	more S	Street, E	Baltim	ore, MD 21	223		
	tate	31. Date filed (Month, Day, Year) JAN 03	2012 32. Registra	ar's Signatu	re 8. 4	arke							
Regis	uell	JANUU											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12/17/2011 ATLANTA ISABEL DOWNES-FRAZIER 0615 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Social Security Number 6. Sex . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🛚 Months Days Hours Min. 07/03/1943 Trinidad Director 123-42-0401 68 Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No MD Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20874 USA 13201 Chalet Place, #102 filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, er than "natural", or iter the Medical Examiner Armed Forces? Black, White, etc. ģ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Yes Give 3 Divorced 4 Divorced Specify: Black Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working I Hygiene. Shady Grove Adventist life. DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) Administrator Hospital vrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ and 2 should be Arthur Massiah Ethelyn A. Downes traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health a James Frazier/spouse 13201 Chalet Place, #102, Germantown, MD 20874 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Gate of Heaven Cem. 12/23/2011 Silver Spring, MD permit. 21. Signatul of Funeral Service Licensee 22. Name and Address of Facility Snowden Funeral Home MO1576 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Acute Arrhythmia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause in page 1975. Due to (or as a consequence of): Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last burial attending physiciar Physician/Medical that the death certificate be P.O. Box 68760 as the b IF FEMALE: ase yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months'
1 Yes 2 XNo
9 Unknown ò Month Year Pregnant at time of death detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 X Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒No 24a. Was an has autopsy perform After this certificate Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗓 No ၉ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA npleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred X Natural 5 Pending injury work?
1 ☐ Yes 2 ☐ No dealth. Investigation 6 Could not be Accident To the Hospital or Atterwithin 24 hours effer deat To the Funeral Director Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 0 D51980 12/17/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Rockville, MD 20850 Brett Gamma, MD 31. Date filed (Month, Day, Year) State

Registrar

NFC 2 0 20

Devine Wilford 12-10-11 10:23

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		-	For State		-	•				and iv	ептаг пу	_	2111	42582									
	1. Decedent's Name (First, Middle, Last) 2. Date of Death 2. Date of Death									3. Time of Death													
	Physicia Medic		Wilford E. Devi	.ne							12/10	/11 ^D	ay Year	10:23 A ^M									
, dans,	Examin		4a. Facility Name (if not institution, give str	reet and number)			4b. City, Tow	/n, or l	Location o	of Death			c. County of Dea	th									
	·		Suburban Hospital				Beth						Montgom										
	Funeral Director		5. Social Security Number 554-42-3369 Usual Residence of Decedent	7. Age	(In yrs. last	birthday) Yrs.	If Under 1 Y Months D	ear ays	If Under: Hours	24 Hrs. Min.	8. Date of Bir 01/11/		g. Bir	thplace (State or Foreign Littornia									
	aryland la-f show ified at	ector	10a. State 10b. County MD Montgomer	у	-	Town or Loc nesda	ation							10d. Inside City Limits 1 ★ Yes 2 □ No									
	with the M 23a or 26 ist be not	Funeral Director	10e. Street and Number 8401 Irvington Ave	nue			10f. Zip Co	de 2	0817			-	itizen of What C	-									
980	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ρ	11. Marital Status 1 ↑ Never Married 2 ↑ Married 3 ↑ Widowed 4 ↑ Divorced	2. Was Decedent Example Forces? 1 X Yes 2 1 If Yes, Give Year or Dates.		If	Vas Decedent Yes, specify (Cuban	, Mexican	gin? (Spe , Puerto l	cify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit Specify: Wh										
Maryland 21215-0036	thin 72 hou ine. than "natu se Medical	Completed	omplet	15. Decedent's Edu (Specify only highest grade Elementary/Seconday (0-12)	completed) College (1-4 or 5-	′	(Give k	ent's Usual O ind of work do NOT use ret	one du ired) SIL	uring most ion		ng		Kind of Business	,								
2	ed with	ക	17. Father's Name (First, Middle, Last)	5+		GII	· OI E		18 Moths		e (First, Middle			of Maryland									
rylan	uld be file d Mental marked o natic eve	욘	Clifford Devine 19a. Informant's Name/Relationship (Type	Ovint					(C i la	Hatler			. 6. 4.)									
	ind 2 sho fealth and im 27 is i		Boyd Hagy / Half-Br			8401	Irving	gto		enue	Bethes	da.	or Town, State, Z	.7									
Baltimore,	permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cerr	etery, creme of I	sition (Name c natory or other Heaven	ce:	met,	12/14		Sil	Location - City o	ng, MD									
Balt	permit. Page 'Department o Important: If any injury or once.		21. Signatury of Funeral Service Licensee	Buyar		²² 5	Name and A	ddress SCO	s of Facility nsin	Ave.	eph Gaw . NW Wa	ler shi	s Sons	Inc. 0C 20016									
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enshock, or heart failured List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Medical Examiner Myocardial Infar Due to (or as a consequence of): Coronary Artery Sequentially list conditions,						rction							Approximate Interval Between Onset and Death 3 Days									
00	cate be executed physician and s the burial-traesing.	Physician/Medical Examiner																					
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. FIRE Funeral Director: After this certificate has been signed by the attending physicical properties of the funeral director, page 2 should be detached for use as the but the funeral director.		ysician/Med	nysician/Mec	nysician/Med	nysician/Med	nysician/Med	nysician/Med	ıysician/Mec	nysician/Med	nysician/Mec	ysician/Med	nysician/Me	nysician/Med	nysician/Med	FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23d. Date 23d. Dat							23d. Date of de Month
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Division of Vital Records,	sician: The law require certificate has been si irector, page 2 should	Completed									24a. Was auto perf 1 \(\sum \) Yes	psy ormed?	prior to death?	utopsy findings available completion of cause of									
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ion of	Attending Pr or death. ector: After th by the funeral	Certificate:	27. Manner of Death 1 XNatural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day,	28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? 1 Yes 2 No 28d. Describe how injury occ																		
Divis	spital or Attend ours after death teral Director; / filled in by the f		4 Homicide determined	28e. Place of Injurbuilding, etc.	. (Specify)						City or To	wn, Stat	'e)	ural Route Number,									
	o the Hospital vithin 24 hours the Funeral	Medical	only one) 3 Certifying Nurse	r: On the basis of ex	amination a	nd/or invest	igation, in my death occurred	opinior at the	n, death oc time, date	curred at	the time, date	and place he cause	ce, and due to the e(s) and manner a	cause(s) and manner stated s stated.									
a	7		29b. Signature and the of certifier						number 4770	5		29d. D	eate signed (Mon	th, Day, Year)									
		i	30. Name and address of person who cor Lori Pihl MD 8600					esd	a, M	D 208	814	7											

State Registrar 31. Date filed (Month, Day, Year) **DEC 15 2011**

3. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12:45 PM Bernardine Wiczer Dodek 12 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number Age (In yrs. last birthday) **Funeral** Days Hours Min (Month, Day, Year) Director 577-54-8370 1 □ M 2 🗓 F 71 01-02-1940 Washington D.C. Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 X Yes 2 No MD Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20854 United States 12808 Huntsman Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. þ 1 Never Married 2 X Married ☐ Yes 2X☐ No Yes, Give 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours popartment of health and Mental Hygene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Education Biology Teacher/Horticulture Be Baltimore, Maryland 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ Sol Brown Wiczer Sylvia Kurland Wiczer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel M. Dodek II - Spouse Huntsman Way, Potomac, MD 20854 12808 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garden of Remembrance 12-11-2011 Clarksburg MD Signature of Funeral Service Licensee 22. Name and Address of Facility Edward Sagel Funeral Direction, Rockville Pike, Rockville MD 20852 Edward Sagel #M00910 Inc. 1091 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between 23a. Part shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final metastasis Physician/ Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): as the burialanding physician a use as the burial. Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter for u in the past 12 months? 1 ☐ Yes 2 D No 9 ☐ Unknown Month Day Year Pregnant at time of death 5 Other (specify) signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of cate has ; page 2 s autopsy perform 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA ၉ 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: After injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No thin 24 hours after death.

the Funeral Director: At ompletely filled in by the fu Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one December 8,2011 37024 and bodiess of person who completed cause of death (Item 23a) (Type, Print)

ANIO SRIVIN MD 9901 Medical Car & Rockville, MD 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature 1 5 2011 Registrar

1250

Bernardine

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	- State Amend Items	State of Mary 25,27,28a-	land / Depa f per me Cer	rtment of H 9926,04 7 difficate of D	ealth and M 19/2012dh leath	lental Hygi ib	eg. No. 201	1 42684		
	Physicia	n/	1. Decedent's Name (First, Middle, Las	,	Peter A. Del Grosso				n 2r 15, 2011	3. Time of Death 1:50 p M		
	Medic Examin		4a. Facility Name (if not institution, give	street and number)	r) 4b. City, Town, or Location of Death				4c. County of Dea			
	Funeral		Lawrel Regio 5. Social Security Number 6. Se	7. Age (In	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. B	thplace (State or Foreign		
	Director		5//-20-0885	XIM 2 □ F	90 Yrs.	Months Days	Hours Min.	March 2:	5,1921	ountry) Italy		
	land show d at	- 1	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Loc			,		10d. Inside City Limits		
	e Mary r 28a-f notifie	Director	Maryland Prince	George's		10f, Zip Code	illege Pa		0g. Citizen of What 0	1 X Yes 2 No		
	with th	Funeral	3502 Marlbr	lough Way		101, 21,0000	20740			1.S.A.		
	r items iner m	F	11. Marital Status 1 □ Never Married 2 🛛 Married	12. Was Decedent Ever Armed Forces?	in U.S. 13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Am Black, Wh			
903	ırs after ıral", o I Exam	ed by	3 Widowed 4 Divorced	1 X Yes 2 ☐ No If Yes, Give Year or Dates.	1946	☐ Yes 2 🗓 No	Specify:		Specify: (Caucasian		
15-0	72 hou n "natu fedica	Completed	15. Decedent's E (Specify only highest gra	ade completed)	(Give I	lent's Usual Occupa kind of work done do O NOT use retired)	ition uring most of worki	ng	16b. Kind of Busines			
212	within giene. ner tha t, the I		Elementary/Seconday (0-12)	College (1-4 or 5+) 5+	Assis	tant Post				Government		
and	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked of ther than "natural", or items 23a or 28a-f sho is marked other than "natural", or items 23a or 28a-f sho is marked event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last) Micho	iel DelGross	0		18. Mother's Name		Maiden Surname) ela Coppo	bianco		
lary	should and Me is mar aumati	33	19a. Informant's Name/Relationship (T)	/pe, Print)	19b. Mailir	ng Address (Street a	nd Number or Rura	l Route Number,	City or Town, State, 2	Zip Code)		
e, S	and 2. Health em 27.		Brian DelGrosso - 20a, Method of Disposition		2710 20b. Place of Dispo				ng, Marylo			
mor	Page 1 nent of ant: If it		1 ☐ Burial 2 汉 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		cemetery, cren t. Linco:	natory or other place Ln Cremat	ory 12/2	0/2011	Brentwood	, Maryland		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licens		22	. Name and Addres	s of Facility Hin	es-Rinal	ldi Funero	ul Home, Inc.		
I	٠		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Conset and Death									
!	Medical	i	Immediate Cause (Final disease or condition resulting in death)	a. Septic	le Organ	Failure		Onset and Death				
	Examiner			Due to (or as a consequence of): Urinary Tract Insection								
	p 1	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as a co	onsequence of):			1//				
	icate be executed in physician and sthe burial.	l Exa	that initiated events resulting in death) Last	C. Due to (or as a co	onsequence of):		CERTIFICATION APP	MEDICAL	EXAMINER			
200	ate be physici the bu	edical		d		20425						
Box 687	h certific tending r use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p	Fetal death 3	Ectopic pregnanc			23d. Date of o	delivery Day Year		
. Bo	the deat by the at sched fo	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at tim 9 ☐ Unknown	ne of death 5 L	J Other (specify)			- Worker	July 1011		
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending is completed filled in by the funeral director, page 2 should be detached for use as	þ	Part II. Other significant conditions of Respiratory Fa		not resulting in the u	ınderlying cause glv	en in Part I.			to the cause of death? Probably 4 Unknown		
ord	w requi	Completed	Vertebral Body	Fracture				24a. Was a		autopsy findings available to completion of cause of		
Rec	The la cate ha		Spinal Cord Co	mpression				performed? death? 1 □ Yes 2 1 No 1 □ Yes 2 □ No				
Vital	ysician s certifi director	To Be	25. Was case referred to medical examiner? 1 X Yes -2 X No-	Hospital:	2 ER/Outpatie	Othe	ace of Death (Checer: 4 Nursing He		ence 6 Other (Sp	pecify)		
Jo L	ling Ph y I. After thi Uneral I		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Ye		work	/ at ? Yes 2 X No	28d. Describe ho	ow injury occurred S collided	ubject driver with pick-up		
isior	• Attender death • ector: / by the i	Certificate:	2 X Accident Investigatio 3 Suicide 6 Could not b 4 Homicide determined		- At home, farm, str	P	165 2 24 10	of a car collided with pick-up truck 28f. Location (Street and Number or Bural Route Number, City or Town, State) Greenbelt and				
Ω̈́	pital or burs afte eral Dir filled in		29a, Certifier 1 X Certifying Phy	Roadwa	ay	occured at the time		City or Town, State) Greenbelt and Mandan Roads, Greenbelt, MD ce, and due to the cause(s) and manner as stated.				
	he Hos in 24 he he Fun ipleted	Medical	(Check 2 Medical Exam	iner: On the basis of exam se Practioner: To the bes	nination and/or inves	tigation, in my opinic	on, death occurred a	t the time, date and ce, and due to the	nd place, and due to the cause(s) and manner	ne cause(s) and manner stated. as stated.		
			29b. Signature and little of certifier	1:		29c. License	D69430	2	29d. Date signed (Mo December			
	181		30. Name and address of person who	completed cause of death	h (Item 23a) (Type, I	Print)		.0. 1.0				
	-04-	0	Nega Ali Goji, N 31. Date filed (Month, Day, Year)	.D., 7300 V	an Dusen	Road, La	urel, Ma	iykand 2	0/0/			
	Sta Registr		DEC 1 9 201	1 Julia	Signature 4	Ked.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42685 Reg. No. 20 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day $A^{\ M}$ Myrna George Dill 2011 6:35 December 16, 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Caroline Envoy of Denton Denton If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 1 ☐ M 2 🗓 F 213-60-8965 02/22/1939 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No Caroline Denton Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21629 26336 Line Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: 3 X Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Clerk Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alice Liden Robinson Dawson George Hubbard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Federalsburg, Maryland 21632 Nancy Dorman/Daughter 5729 Noble Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State 12/19/2011 Federalsburg, Maryland 4 □ Donation 5 □ Other (Specify) Concord Cemetery 21. Signature of Funeral Service 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street Denton, Maryland 21629 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. EREBRO VASCULAR Immediate Cause (Final disease or condition resulting in death) ATHEROSCIEROTIC CARDIOVASCULAR DISENSE YE Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🙀 No 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 No ISCHEMIC CARDIDMY OPATHY 3 Probably 4 □Unknown 1 Tyes

Physician /Medical **Examiner**

physician and the burial-tran

Department of Health ar Important: if item 27 is any injury or other trauonce.

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

Funeral Director

Completed by

Be

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Examiner

Physician/Medical

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

7 is marked other than "natural", or items 23a or traumatic event, the M-dical Examiner must be

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 5 No 24a. Was an autopsy perform 2 No 2 No

25 No 1 ☐ Yes 28a. Date of Injury (Month, Day Year) 27. Manner of Death

26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28d. Describe how injury occurred

5 Pending investigation 6 ☐ Could not be

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Day,

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

who completed cause of death (Item_23a) (Type, Print)

State Registrar

32 Registrar's Signature

P65

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, d in by the within 24 hours and
To the Funeral Dir

Completed by Be Certification: To

Medical

1 Natural 2 Accident

3 Suicide 4 ☐ Homicide

31. Date filed (Month,

29a. Certifier

determined

🖶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

0053094 MD321 BLOOM INGDALLY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Margaret Eckroth 2011 <u>December</u> 11:15 pM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Silver Spring Holy Cross Hospital Montgomery If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F January 10.1926 England Director 220-26-6563 85 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20902 2102 Plyers Mill Road United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Yes 2 No Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: Caucasian 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Retail e 1 and 2 should be filed wit of Health and Mental Hygie If item 27 is marked other or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sidney Curtice Caroline Hampson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra <u>Valerie Mayor. Daughter</u> <u>HC 66 Box 51-1A. Dryfork. West Virginia</u> 26263 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 12/20/2011 | Brentwood, Maryland 21. Signature uneral Service Licensee MO1102 22. Name and Address of Facility Simple Tribute OUX 1040 Rockville Pike. Rockville. Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Esophageal Cancer disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Pneumonia Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examin To the Hospital or Attending Physician; The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 X No Month Day Year Pregnant at time of death the Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? Yes 2 No death? 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital 1 \sum Yes 2 X No Other: 은 ER/Outpatient 3 DOA 1 X Inpatient 2 -☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After X Natural 5 Pending 1 Yes 2 No within 24 hours after death

To the Funeral Director:

completed filled in by the f 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 20 teted cause of death (Item 23a) (Type, Print) 02V1

DHMH 17 Rev 7/2009

State

Registrar

Date filed.

2 0 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 74M December 21. Featherstone 2011 R. Eleanor Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Prince George's Crescent Cities Center Riverdale If Under 1 Year If Under 24 Hrs. 5. Social Security Numbe 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min 1-28-19 Year Lower Merion, P 96 **Director** 577-56-3233 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director New Carrollton MD Prince George's 1 🏋 Yes 2 □ No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? the Medical Examiner must be Funeral with 23a 20784 United States 5909 Westbrook Terrace items ? 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. P þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: and Mental Hygiene. is marked other than "natural", Specify: Black 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ပ္ Mary Wright Clifton Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4808 Muskogee St. College Park, MD 20740 Michael Featherstone (SON) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 💹 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Fort Lincoln Cemetery 12/31/2011 Brentwood, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Nome 21. Signature of Funeral Se Age Licensee 3401 Bladensburg Brentwood, MD 20722 Rd. homes II 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death teriosa Physician. Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence oi). Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: s, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death ped 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 performed Yes 2 this certificate 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred After injury Natural 5 Pending 2 No 1 Ves Accident Investigation 24 hours after deatl completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the ! only one) 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Day, Year)

CR 3
State

Registrar

Name and address of person

veeps bury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

laria Fabian		State of Maryland / Department of 1-For State Certificate of Registrar		ygiene Reg. No.	2011 4268		
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last) María Alexandra Fabí	an	Date of Death Month Day December 12, 2	3. Time of Death 011 1905 hrs		
·		4a. Facility Name (if not institution, give street and number) 12907 Dean Road	4b. City, Town, or Location of Death Silver Spring	4c.	County of Death ontgomery		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 577-70-7572 1 M 2 X F 55 Yr	If Under 1 Year If Under 24Hrs Months Days Hours Min		DD/YYYY) 9. Birthplace (State or Foreign Country) DC		
land f show any once.	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local Maryland Montgomery	Silver Spr		10d. Inside City Limits 1 Yes 2 X No		
0036 within 72 hours after death with the Maryland siene. the than "natural", or items 23a or 28a-f she Medical Examiner must be notified at once	Funeral Director		10f. Zip Code 20906 as Decedent of Hispanic Origin? (Single) Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	en of What Country? U.S.A. 14. Race - American Indian, Black, White, etc.		
5-0036 led within 72 hours after. Hygiene. Inther than "matural", of	Completed by F	3 Widowed 4 X Divorced If Yes, Give Year 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	Yes 2χ No specify: Int's Usual Occupation (Give kind of nost of working life. DO NOT use ret Stomer Service R	work done 16b. Ki	Specify: White ind of Business/Industry Retail		
야 글 뜻 표 책	a	a	Be	17. Father's Name (First, Middle, Last) Karl Alexander Fabian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailir	18.Mother's Name	e (First, Middle, Maiden S Maria Lo Rural Route Number, City	Surname) 3 binsky y or Town, State, Zip Code)
Baltimore, MD 2121 permit. Pages I and 2 should be fil Department of Health and Mental Impurtant: Utiem 27 is marked injury nr other traumatte event,		1 X Burial 2 Cremation 3 Removal from State RUSSIAN (4 Donation 5 Other Specify: 21. Signature of Furnal Service Licenses 22.	Name and Address of Facility Ha	17/2011 N nes-Rinaldi	lanwet, New York Funeral Home, Inc.		
Physician /Medical Examiner	e	23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):	800 NEW Hamps not	2 AVE., SLU	ver Spring, MD 2090 k, or heart Approximate Interval Between Onset and Death		
be executed sician and the virial - transit	edical Examiner	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): d. UNPENDED AMENDED					
Box 68760, e death certificate be extending physiciar defor use as the burial	ΣI	23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 2 Frequency to time of death 2 Frequ	etal death 3 Ectopic pregnation (Specify)		Date of delivery Month Day Year		
P.O. es that the igned by	Completed by Pi	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	1 Yes 2 🗹	se contribute to the cause of death? No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of		
Division of Vital Records, ral nr Attending Physician: The law requirers after death. a) Director: After this certificate has been sited in by the funeral director, page 2 should be	o Be Com	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatier	26.Place of Death (Check	performed? 1 Yes 2 No only one) ng Home 5 Residen			
Sion of \attending Phydeath. ector: After the	Certification: To	27. Manner of Death 1 Natural 5 Pending Investigation 28a. Date of Injury FOUND: POUND: FOUND: POUND: 1850 hrs	1 Yes 2 ✔ No	28d. Describe how injur Subject shot self			
Hospi 24 hou Funer	_	3 Suicide 4 Homicide Could not be determined Copecify) Single Family Home 29a. Certifier (Check only) Certifying Physician: To the best of my knowledge, death occur	urred at the time, date and place, and	or Town, State) 12907 Dean Road, S I due to the cause(s) and	manner as stated.		
To the within C To the Comple	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigated and manner stated. 29b. Signature and title of certifier Author Miles Aut	29c. License number O.C.M.E.	29d. D	ate signed (Month, Day, Year) ember 13, 2011		
St	ate	30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 90 31. Date filed (Moath Day, Year) 2011 32 Registrar's Signature		more, MD 21223			
Regist	rar	UEC 19 2011 Person A. Dar					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Day 18, Physician/ 4:25 am Franklin Donald Feldman 2011 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring 607 Kenbrook Drive 7. Age (In yrs. last birthday) lf Under 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number Funeral Months Hours Min (Month, Day, Year) 577-44-4579 Director 1 🗶 M 2 🗆 F 78 Yrs 02/03/1933 Pennsylvania Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State the Maryland Director 1 Yes 2 X No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with U.S.A. 20902 607 Kenbrook Drive items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status "natural", or iter dical Examiner was Decedent Ever in 6.5.

Armed Forces?

1 ☑ Yes 2 □ No 1953-Black, White, etc. ρ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced 1955 White d other than "nau.... Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Retail Liquor Business Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I ပ Ruth Foreman Sydney Feldman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 607 Kenbrook Drive, Silver Spring, Maryland 20902 Barbara Ann Feldman - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State King David Mem. Grdns 12/21/2011 | Falls Church. VA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Wà 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, t and Death
Years Immediate Cause (Final Physician/ Non Small Cell Lung Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 13 Years Brain Metastases Sequentially list conditions. Examine Due to for sels to readlier ex th rial-transit cause. Enter Underlying that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical use as the bur Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death ed by the a 1 Yes 2 g Unknown Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Acoustic Neurona 1 ☐ Yes 2 ☐ No 3 🛣 Probably 4 ☐ Unknown The law requires Completed Were autopsy findings available prior to completion of cause of 24a. Was an Prostate Cancer page 1 Yes 2 No Yes 2 X No Division of Vital 26. Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medica Be examiner? Hospital Other: 2 🗶 No 1 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 K Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred s after dea. 1 X Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined within 24 hours af

To the Funeral D

completely filled i Medical 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) December 19, 2011 D35996 10H llong

Registrar

DHMH 17 Rev 06-2011

State

2730 University Blvd., #400, Wheaton, Maryland 20902

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Linda Burrell,

DEC 2 0 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 42690 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month FRAGER Anne December 2011 2:35 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Silver Spring **Examiner** 4c. County of Death Montgomery Alfred House Eldercare If Under 1 Year | If Under 24 Hrs. . Social Security Number 7. Age (In yrs. last birthday) 94 yrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 286-07-3735 1 ☐ M 2 ☐ XF Director Onio Dec. 1916 Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring Maryland Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code Hygiene. other than "natural", or items 23a or vent, the Medical Examiner must be ! 10g. Citizen of What Country? Funeral 20906 United States 4 Broomall Court within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify: White 1 ☐ Yes 2 🕅 No Specify: 3

✓ Widowed 4

□ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home : should be filed w n and Mental Hyg Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked ပ Rebecca Weissman Herman Koral 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 2200 Aventurine Way, Silver Spring, MD Gayle Miller, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 \int Burial 2 \subseteq Cremation 3 \int Removal from State 4 \subseteq Donation 5 \subseteq \text{Other (Specify)} cemetery, crematory or other place) 12/20/11 Olive Cemetery Solon, OH Signature of Funeral Service Licensee Torchinsky Hebrew Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20012 Approximate Interval Between Onset and Death Years Immediate Cause (Final Physician/ disease or condition resulting in death) <u>Alzheimer's</u> Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 \square Yes 2 X No 3 \square Probably 4 \square Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No To the Hospital or Attending Physician: "
within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner?
1 ☐ Yes 2 🌠 No Be 26. Place of Death (Check only one) Hospital Other: 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 W Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending injury 1 Yes 2 No Accident Investigation M 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) December 19, 2011 D 18813 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ira Tauber, M.D., 10301 Georgia Ave., #304, Silver Spring, MD 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 42691 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FIELD S VICTOR 10: 40A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CENTER SILVER SPRINO GENESIS LAYHILL MONTGOMER If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8, Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🛛 M 2 🗆 F Min Poland Director 543-30-2957 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at 72 hours after death with the Maryland Director 1 Yes 2 X No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 20906 3005 S. Leisure World Blvd., #404 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. and Mental Hygiene. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced 1971 Caucasian Year or Dates any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) **5**+ Elementary/Seconday (0-12) Psychology Psychologist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ida (Unknown) Nathan Rosenfield 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Barbara Ochsman - Daughter 40474 Quarter Branch Road, Lovettsville, VA 20180 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of H Important: If ite Page 1 1
Burial 2
Cremation 3
Removal from State Lincoln Crematory 12/14/2011 | Brentwood, Maryland 4 Donation 5 Other (Specify 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Light Neva 11800 New Hampshire Ave., Silver Spring, MD 20904 1401621 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DEMENTIA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): ttending physician and or use as the burial transit Cause (Disease or Injury that initiated events that the death cerificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical 09289 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Box (in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Pregnant at time of death ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Records, Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗀 No 1 Tes 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Be Hospital 1 Tyes 2 မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 1 Natural 5 Pending injury work? 1 ☐ Yes 2 🗆 No To the Hospital or Attending within 24 hours after death.

To the Funeral Director: At completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical certifying Physisian: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

M. dical Examples: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Check 3 Certifying North Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0064208 13 Completed cause of death (Item 23a) (Type, Print) 30. Name and address of person BELPRE ROAD SILVER SPRING 20906 MD 3227

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBER 2011 10:25A FRANCES GILROY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 ☐ M 2 ☐ F 8 Month / Pay 9 274 216-22-7935 87 Gountry) **Director** Usual Residence of Decedent ems 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 72 hours after death with the Maryland Director 1 Yes 2 No MD Frederick Middletown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8132A Bolivar Rd. 21769 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black White etc. ō 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify White "natural" Completed 3 Divorced 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Ith and Mental Hygiene. 27 is marked other than ' traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) own home homemaker Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I-Important: If item 27 is marked or any injury or other traumatic even James Miley Gilroy Frances Shank 19a. Informant's Name/Relationship (Type, Print)
Karen Gilroy (Sister) 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8132A Bolivar Rd., Middletown, MD 2176920a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Lutheran cemetery 12/16/2011 Middletown, MD Donation 5 Other (Specify) Bonard ddgss of Thompson Funeral Home f Funera X ervice Sinature Middletown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Ima ediate Cause (Final Physician/ dis se or condition resulting in death) Medical Imbilical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and -transit The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last burial attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day Year 5 Other (specify) Pregnant at time of death signed by the a d be detached f Unknown 9 Unknown P.O. Part II. **Other significant conditio**ns contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy has certificate Yes 2 N Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\) Other (Specify) 1 Yes 2 X No 1 Inpatient 2 X ER/Outpatient 3 I DOA ဂ္ this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral or 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 29c. License number 3 201 MOD 35267

State Registrar

3

Manuel

31. Date filed (Month, Day,

A

Year)

400

Frederick, mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mo

32. Registrar's Signature

Casiano

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 1 Day4, 2011 Physician/ 5:05 Ам ALMERETTA THERESA GRAY Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Frederick Memorial Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth Nov 13 Year) 917 1 🗆 M 2 🗓 F 213-12-3044 Illinois 94 **Director** Usual Residence of Decedent 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 Yes 2 XX No Ijamsville Frederick Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21754 3438 Big Woods Road United States items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten edical Examiner r 11. Marital Status 14. Race - American Indian Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify Specify: 3 XX Widowed 4 □ Divorced Completed Year or Dates Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) the 12 Social Worker State Government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ith and Mental H 27 is marked of traumatic ever Arlie Smith Edward Percy Tyson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3438 Big Woods Rd., Ijamsville, MD 21754 19a. Informant's Name/Relationship (Type, Print) nt of Health a t: If item 27 is r or other trai Christina Fitz / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Restnaven
Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State 1 ☎ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or Frederick, Maryland 4 Donation & Other (Specify) 21. Sign of Funer Service License Resthaven Funeral Services, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause Final disease or condition resulting in death. Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, MD 21701 Approximate Interval Between Onset and Death Physician Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 4 Pregnant a Pregnant at time of death the 9 Unknown Division of Vital Records, P.O. ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by OUTEGARTHRITTS 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an After this certificate has autopsy within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, t 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) 29b/Signature and the of certifier မ 29d. Date signed (Month, Day, Year) 121936 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOMAS GHANON DE FRENERICK 6500 DONEWON MD

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

16

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Marjoray Earle Geraci 2011 December Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery 9501 Colesville Road Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral Hours 214-03-8021 91 Director 1 □ M 2 🏻 F March 31, 1920 Virginia Usual Residence of Decedent 28a-f show 10c. City, Town or Location Examiner must be notified at Director Montgomery Silver Spring or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 9501 Colesville Road 20901 USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 1 Never Married 2 Married Completed by 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2X No Specify: "natural", 3 X Widowed 4 ☐ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 10 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ruth Clarke Lawrence Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 419 Branch Drive, Silver Spring, MD 20901 Ruth P. Ireland/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date George Washington George Washington Cemetery 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Dec. Adelphi, MD 4 ☐ Donation 5 ☐ Other (Specify) Prancis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, Signature of Funeral Service Vicensee Mu 23a. Part 1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ a Advanced Dementia Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the buring transit Cause (Disease or injur that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2X No Month the 9 Unknown P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification of the funeral director, sompletely filled in by the funeral director, 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one examiner? Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Kesidence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 K Natural 5 Pending work? 2 Accident 2 No Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one of cartified ne and address of person who completed cause of death (item 23a) (Type

9:00 a M

10d. Inside City Limits

1 Yes 2 No

MD 20901

Approximate Interval Between Onset and Death

than

Year

year

more

Day

20

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day,

Year)

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month 12 4:00 AM Physician/ ons 201 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Adventist TONT Goner HOSPITI Koma Washington 9 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** Min Buffalo 1 □ M 2 🗓 F 81 **Director** 114-32-2811 Usual Residence of Decedent 10d. Inside City Limits or 28a-f show 10c. City, Town or Location 10a. State 10b. County filed within 72 hours after death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 🗆 Yes 2 🏝 No MD Prince Georges Hyattsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 4916 LaSalle Road #15 20782 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces Black White, etc. 1 X Never Married 2 Married ☐ Yes 2 🛛 No þ Baltimore, Maryland 21215-0036 1 Yes 2 X No White If Yes, Give "natural", 3 Divorced 4 Divorced Completed Year or Dates the Medical 16h Kind of Business Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Development Center Social Worker 5+ Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked out any injury or other traumatic event 17. Father's Name (First, Middle, Last) ည Frank Anthony Gawronski Agnes Ann Oczkowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2501 Calvert St., NW Washington, Mary Eleanor Gawronski/Sister D.C. 20b. Place of Disposition (Name of cemetery, grematory or other place)
Metropolitan
Crematory 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2011 Alexandria, Virginia DeVol Funeral Home MO1315 22. Name and Address of Facility eral 🚮 21. Signatur 2222 Wisconsin Ave., N.W. Washington,DC 20007 To LEU 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician umonia disease or condition Medical resulting in death) Due to (or as a consequence of): Éxaminer Sequentially list conditions, if any, leading to immediate cause Enter Underlyin Examiner Due to (or as a consequence of): To the Hospital or Attending Physiclan: The law requires that the death certificate be executed Cause (Disease or iinjury cate has been signed by the attending physician and page 2 should be detached for use as the burial tren that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Year in the past 12 months? Month Day Pregnant at time of death g Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Tonknown Completed Stenosi 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certificate: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No Accident Investigation completed filled in by the 6 Could not be Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00063703 12 me lŪ Carroll AVENUE 7600 20912 Sabyasachi Kar, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

Registrar

DEC 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 28a-f per 0CME 1/9/12 dk
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 20 42696 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2120 M 01 pharon aanne Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner of Manyland Med Ba BALTIMORE CITY Hunore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 11-2-1947 Months Hours 214-52-5526 1 □ M 2 🛣 F **Director** WASH., D.C. 64 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits with the Maryland 10c. City, Town or Location notified at Director MD. 1 Tes 2 XNo CHARLES INDIAN HEAD 10e. Street and Number ŏ 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 103 CIRCLE AVENUE 20640 U.S.A. items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian the Medical Examiner Black, White, etc. 1 Never Married 2 Married ò þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify:WHITE "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) DENTAL ASSISTANT DENTAL OFFICE 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ္ other traumatic RICHARD FLOYD WEIGHTMAN ARLENE DOROTHY LEMNAH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau DIANE L. LOBAUGH-SISTER 8800 LOWELL RD. POMFRET, MD. 20675 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) WA cemetery, crematory or other place) WASHINGTON NAT. CEM. 12-15-11 | SUITLAND, MD. 21. Signature Funeral Service Licensee M00479 . Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 2 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Schemic disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER da Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to lor as a consequence of attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Dav Pregnant at time of death Year signed by the at Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No page 2 has this certificate 1 Yes 2 No Division of Vital • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certific. completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) Hospital Yes 2 🗆 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? un thoun. TOURA ARROW Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Home Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3[To the I within 2 To the I only one 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 101386 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephanie Lucke 22 S GREENE ST Baltimore, mD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 9 2012 Registrar DHMH 17 Rev 06-2011

ORIGINAL

Dr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 42697 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month December 2011 8:50 P.M 01ga В. Gonzalez Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery Village Health Care Center Montgomery Village Montgomery If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Month, Day, 1 🗆 M 2 🖾 F Min 88 Director 577-58-9794 Ecuador Usual Residence of Decedent show 10a State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20874 18003 Mateny Road, # 200 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2X No
If Yes, Give
Year or Dates. Black, White, etc. 9 1 X Never Married 2 ☐ Married Maryland 21215-0036 Yes 2 No Specify: Specify: "natural" Completed 3 Widowed 4 Divorced Ecuadorian Hispanic of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 6 Beautician Salon Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filk Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve Rafael Gonzalez Maria Herrera T.112 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carlos Murillo/Nephew 12910 McCubbin Lane, Germantown, Maryland 20874 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Columbia Gardens Cem. 12/16/2011 Arlington, Virginia tue of Funeral Service Lic see 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Physician/ Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner <u>Acute Renal Failure</u> Sequentially list conditions, Examine ie attending physician and Due to (or as a consequence of) if any, leading to immediate or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Hypertension Due to (or as a consequence of) resulting in death) Last Physician/Medical Diabetes Mellitus Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ed by the atter detached for u in the past 12 months?
1 ☐ Yes 2 🛣 No Month Day Year 5 Other (specify) 9 Unknown sate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Uterine Cancer Completed 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Anemia autopsy performed? 1 Yes 2 X No this certificate 1 🗌 Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner?
1 Yes Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 X Natural 5 Pending work' Investigation 6 Could not be 1 Yes 2 No 2 Accident 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Hospital (

Registrar

29b. Signature and title of certifier

Vinu Ganti, M.D., 31. Date filed (Month, Day, Year)

DEC 1 5 201

QQ1

30. Name and address of person who completed cause of death (Item 23a) (Type, Frint)

Gentifying Nurse Practioner: To the best of my knowledge, death occurred at the time date and place, and discto the name (s) and manner as estated

19529 Doctors Drive, Germantown, Maryland 20874

29c. License number

D41162

29d, Date signed (Month, Day, Year)

December 13, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#11perINF, G943, 9/9/2013, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dec<u>ember</u> Day Physician/ 8:45 am 09. 2011 Ernest Gray Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hebrew Home of Greater Washington Montgomery Rockville 8. Date of Birth (Month, Day, March 1 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs 9. Birthplace (State or Foreign Funeral Country) A<u>ustria</u> 1 🔀 M 2 🗆 F Months Days Hours Min Director 85 130-18-8603 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland if item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at Director 1 Tes 2 No Maryland Silver Spring Montgomery 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 412 Kimblewick Drive 20904 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. þ 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😿 No Specify: If Yes, Give Year or Dates Caucasian Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 }
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event". (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Physicist Research Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Alice May Cornel Grau 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9425 Holbrook Lane. Peter L. Grau - Son Potomac. Maruland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State incoln Crematory 12/19/2011 | Brentwood, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ EMIC disease or condition resulting in death) Medical Due for as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Year Pregnant at time of death Month Day 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? NSONISM -3 Probably 4 Unknown Division of Vital Records, After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 Yes 2 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accident injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifier 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SH ING 31. Date filed (Month, Day, Registrar's Signature

Registrar

hristopher Lee	He	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene	269
		1- For State Certificate of Death Reg. No.	203
Physici Medical Exami		Christophen Lee Hepter December 29, 2011 Year 1013	
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death Westminster Carroll	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 170-70-1396 1 M 2 F 7. Age (In yrs. last birthday) 170-70-1396 1 M 2 F 7. Age (In yrs. last birthday) 170-70-1396 1 Months Days Hours Min. 170-70-1396 1 Months Days Hours Min. 170-70-1396 1 M 2 F 170-70-1396 1 Months Days Hours Min. 170-70-1396 1 Months Days Hours Min. 170-70-1396 1 Months Days Hours Min. 170-70-1396	ite or
nd show any ice.	_	DA MICH	e City Limits
th the Maryland 23a or 28a-f shown notified at once.	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 321 Fox Knoll C+. 17331 USA	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, White, etc. 15. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. Yes, specify Cuban, Mexican, Puerto Rican, etc.) 17. Was Decedent Ever in U.S. 18. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 19. Specify: Spec	Black,
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nore, MD 2121 ages I and 2 should be fil nt of Health and Mental I it: If item 27 is marked other traumatic event,	To	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 321 Fox Kwill Ct. Hower, DA (733)	
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Physician Wedical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a. Oxycodone and Ethanol Intoxication	nate Interval n Onset and Death
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Division pital or Atteodii ours after death.	Certification:	2 X Accident Investigation 3 Suicide 6 Could not be determined (Specify) found in trailer and alcohol 10 12-29-11 fd 10:04 am and alcohol 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 4060 Ridge Rd. Westminster, Md.	umber, City
Division To the Hospital or Atteod within 24 hours after death. To the Fuoeral Director: completely filled in by the f	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. One) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
P 3 F 3	¥	29b-Signature and title of certifier 29d. Date signed (Month, Day, Ye O.C.M.E. 29d. Date signed (Month, Day, Ye December 30, 2011	ar)
		30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
St Regist	ate rar		

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AMES HICKS 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MODICAL ANNAPOLIS, MO ARUNDEL ANNO ARUNDER CTK 219-48-11656 **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 XM 2 □ F June 24, 1945 Washington, DC **Director** Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Edgewater 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 144 Washington Road 21037 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1

Yes 2 □ No or. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes. Give IT Yes, Give Year or Dates 1964-1966 3 Widowed 4 X Divorced Specify: White Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (012) College (1-4 or 5+) and Mental Hygiene. Shelf Stocker Grocery Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James C. Hicks Marie Dodson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i 1921 Harbor Drive Chester, Maryland 21619 Susan C. Stinchcomb -sister 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory12/22/2011 20c. Location - City or Town, State Page 1 permit, Page 1
Department of I ó Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Bonald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, U.150 Maryland20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) NEUMONIA Medical Examiner Alcoholism Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or linjury that initiated events resulting in death) Last death certificate be executed HYPOXIC Tespiratory Due to (or as a consequence of) anding physician use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No jo Month Day Year 1 Yes 2 L 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ś Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was an autopsy performed 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ၉ 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death.

To the Funeral Director; Af completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 6616 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 medical PArkway State

Registrar DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 3450 Nannie Mae Hill Medical 4c. County of Death 4a. Facility Name (if not institution, give street and numbe 4b. City, Town, or Location of Death **Examiner** REGIONAL 544156414 VICOMICO If Under 1 Year | If Under 24 Hrs Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days 219-36-6623 1 □ M 2 🛛 F Director 10-8-1938 73 Usual Residence of Decedent DE an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland Director 1 Yes 2X No Seaford DE Sussex 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 19973 18 Garden Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 XNo 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 SpecifWhite If Yes, Give Year or Dates 1 ☐ Yes X☐ No Specify. Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Poultry Industry Laborer 11 Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ည Dorothy Irene Sharp John Morris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5415 Wellington Dr, Tappe, MD 21673 Michael Hrynko/Son 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other pace. 1 Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cremation, 12-20-2011 Dover, DE 22. Name and Address of Facility 917 W. Isabella St. Bennie Smith Funeral Home Salisbury, MD 21801 Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASCVD Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the how Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? Month Dav 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \) 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: To 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 🔲 Yes 2 🔲 No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
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Babulal

31. Date filed (Month, Day, Year)

DEC 21

Milford ST. # 504 B, Salisburg,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

106

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Thomas Joseph Horrigan December 5:30 aM 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital 01ney Montgomery 9. Birthplace (State or Foreign Country) MA Social Security Number If Under 1 Year Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, 1 X M 2 Min 120-20-3986 83 Director May Usual Residence of Decedent shov 10a. State 10c. City. Town or Location 10d. Inside City Limits with the Maryland notified at Director 28a-f MD Montgomery Burtonsville 1 Yes 2X No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? pe I Funeral ral", or items 23a Examiner must b 14305 Old Columbia Pike 20866 USA permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ 1 XYes 2 □ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White "natural", 3 Divorced Completed WWII Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Police Officer Metropolitan Police Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked ot r other traumatic even ည Stephen J. Horrigan Annie Moran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Agnes E. Horrigan/Wife of Health a 14305 Old Columbia Pike, Burtonsville, MD 20866 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Department or Important; If any injury or ò Gate of Heaven Cemetery Dec 116 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD of Funeral Service Ligensee 21. Signatur 72. Name and Address of Facility Francis J. Collins Funeral Home 00 University Blvd. W., Silver Home Inc. Lver Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each whe. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of): disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of) and Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the burial Physician/Medical that the death certificate be Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months' Month Dav Pregnant at time of death 2 No signed by the a 9 Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform this certificate Yes 2 No 1 Yes 2 No impleted filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 No ၉ 1 Minpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 28a. Date of injury (Month, Day, Year) s after death.

Director: After the 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural work? injury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

B ichhum 29d. Date signed (Month, Day, Year) 754996 December 15 2011

Registrar

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30. Name and address of per a line of the second se

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	Physicia Medic		Rachel Lee Hurley				lI	Nonth Decembe	er 1	0.0, 20	i	2305	М		
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فممد			Shady Grove Adventist Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd)	au) If	Rockv Under 1 Year	ille I If Under	24 Hrs	8. Date of Bir	_	Montgo		e (State or	r Foreign		
	Funeral Director		269-14-5344 Usual Residence of Decedent	Mo	onths Days	Hours	Min.	(Month, Da	ay, Year)		Country)		roleigh		
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10a. State 10b. County 10c. City, Town of Caither MD Montgomery Gaither								10d.	Inside Cit			
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Q	Hospital 4 hours a 5 uneral tely filled	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, de (Check 2 Medical Examiner: On the basis of examination and/or in									(s) and mai	nner stated.		
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			30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print		001	, ,		DE	CEMBI	ck 1	0 6	011		
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State of Maryland / Department of Health and Mental Hygiene 2011 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2011 December 6:00 A M John E. Harris, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 9408 Tiller Drive Ellicott City Howard If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth Funeral Maryland Days (Month Day, Year) an 2, 1941 1 🔀 M 2 🗆 F Months Hours Min **Director** 70 220 36 4677 Jan Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location with the Maryland at 10d. Inside City Limits Director notified 28a-f 1 Yes 2 No MD Ellicott City Howard 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? ò the Medical Examiner must be Funeral items 23a 9408 Tiller Drive 21042 United States death \ 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14 Bace - American Indian Armed Forces?
1

Yes 2 □ No If Yes, specify Cuban, Mexican, Puerto Rican, etc." Black, White, etc. 1 X Yes 2 No
If Yes, Give
Year or Dates.1959-65 ō δ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: and Mental Hygiene. is marked other than "natural", Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Self Employed <u> Attorney At Law</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Earle S. Harris Florence Child permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9408 Tiller Drive Ellicott City, MD 21042 Jayme L. Harris/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Kemoval from State St. John's Cemetery | 12-21-2011 Ellicott City, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHarry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final trostate ₽nysician/ Cancer disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): and -transit Exami death certificate be executed Lause Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): burial attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant a Pregnant at time of death 5 Other (specify) ed by the a g Unknown Hospital or Attending Physician: The law requires that the signed by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, 2 No 3 Probably 4 Unknown 1 Yes Completed been si should I 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s autopsy performed? certificate 1 Yes 2 No Yes 2 😾 No Division of Vital After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 XNo 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 X Natural 5 Pending Accident death. within 24 hours after death

To the Funeral Director: /
completed filled in by the f Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one 29b. Signature and title of certific 29c. License number 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed of ause of death (Item 23a) (Type, Print) MO 21231 Orleans 31. Date filed (Month etrar's Signature State Registrar MARIE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 3 2011 Physician/ 5:29 A M Emory S. Holland Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8235 Averill Ct. Severn Anne Arundel 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1**X**] M 2 □ F Director 137-76-9623 Oct 23 1980 New Jersey 31 Yrs Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location aţ Director notified 28a-f 1 ☐ Yes 2X No Severn Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö must be items 23a Funeral 8235 Averill Ct. 21144 USA · death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Forces?

1 Yes 2 No Black, White, etc. o, 1 Never Married 2X Married þ Maryland 21215-0036 hours after 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: Black "natural" Completed 3 Widowed 4 Divorced Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Express al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) the Professionals 12th Labor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Department of Health and Ment: Important; If item 27 is marked any injury or other. Dorcell McGowan Emory S. Holland Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Severn, Md. 21144 8235 Averill Ct. Chanel L. Holland(Wife) Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b (fileen Dis Haiv eine of Date 1 X Burial 2 Cremation 3 Removal from State Memorial Park 12-20-11 Glen Burnie, Md. 4 Donation 5 Other (Specify) Wmane Research & Sons Mortuary, P.A. 21. Signature of Funeral Service Licenses Lavy 1 1922 Forest Dr. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or injury that initiated events resulting in death) Last burial-tra Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be P.O. Box 68760 the as IE EEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Pregnant at time of death the i ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I þ To the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 : autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes Other: 4 Nursing Home 2 🔲 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Within 24 hours after ueau..

To the Funeral Director: After 1

-1-Ant filled in by the funer Certificate; UNKM HIMSELF 1 🔲 Natural 5 Pending JUN. work? 1 ☐ Yes 2 🔼 No 12/14/11 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) building, etc. MD tome Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier . Deputy 29d. Date signed (Month, Day, Year) ress of person who completed cause of death (Item 23a) (Type, Print) ONKS mD

State Registrar Redistrar's Signature

DEC 16

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Willie Hill Month Dec. 201 1002 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth
Jul. 14, 1939 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country). 7. Age (In yrs. last birthday) **Funeral** Days Hours **Director** 244-52-4047 1 **№** M 2 □ F 72 Usual Residence of Decede 28a-f show 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Lothian 1 Yes 2 No 10f. Zip Code 20711 10g. Citizen of What Country? 10e. Street and Numbe Funeral 5239 Sands Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Yes Give Specify: Black 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Building Supervisor Public Schools Be 18. Mother's Name (First, Middle, Maiden Surname) Roxie Jones 17. Father's Name (First, Middle, Last) Hill Robert traumatic ge 1 and 2 should but of Health and Mer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TaWanda Waters/Step-daug. 1790 Parkers Creek Rd. Port Republic,MD20676 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 ; cemetery, crematory or other place) 1

Burial 2 ☐ Cremation 3 ☐ Removal from State Injury or permit. Page Department of Important: If any Injury or Moses Cemetery 12/22/2011 Lothian, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sewell 1451 Dares Beach Rd. . Signature of Funeral Service Licensee Funeral Home, P.A. Prince Fred., MD2067 Blacky 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate once. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) and burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be Box 68760 the as IE EEMALE nse yes, outcome of pregnancy
Live Birth 2 D Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Dav Year 5 Other (specify) Pregnant at time of death 1 Yes 2 No ate has been signed by the a page 2 should be detached g Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 🗌 Inpatient ER/Outpatient 3 DOA completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only o 29d. Date signed (Month, Day, Year) D16376 Dec. 13, 2011 32. Registrar's State 20 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December Day 3. 6:52 рм 2011 Mary T. Henning Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hill Haven Assisted Living Adelphi 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Months Hours Min. Washington. 91 Director 578-18-5631 Usual Residence of Decedent 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Silver Spring Maruland Montaomeru 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1402 Oakview Drive 20903 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian þ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 🗓 Widowed 4 🗆 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Printing should be filed with h and Mental Hygien 7 is marked other th Proofreader Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carl Tredway Sophie K. Bruegger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 2001 Ruatan Street, Adelphi, Maryland 20783 Brian W. Henning - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Mem. Grdns. | 12/29/2011 | Rockville. Maryland 4 Donation 5 Other (Specify) 21. Signature of Fune al Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that the death certificate be executed that initiated events Due to (or se consequence of): resulting in death) Last attending physician for use as the burit Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) 1 ☐ Yes ∠☐ g ☐ Unknown Unknown Division of Vital Records, P.O. Ś Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be det Completed by Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of has autopsy perform certificate 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After t completed filled in by the funeral 1 Natural 5 Pending work? 2 🗌 No Acciden Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signatur and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

166 Rd # 216 ROCKVILLE MD 20852

experson who completed cause of death (Item 23a) (Type, Print)

1 9 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 18, 2011 2:00 P Mali ILKOVICH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Hebrew Home of Greater Washington Rockville 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 6. Sex Funeral 1 | M 2 | XF Nov. 24, Year 1924 Months Days Hours Ukraine Director 217-21-4791 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 XNo Rockville Maryland Montgomery 10f. Zip Code 0 10e. Street and Number 10g. Citizen of What Country? items 23a United States 20852 6111 Montrose Road #920 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. "natural", or 1 Never Married 2 Married \$ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: Completed 3 ☐XWidowed 4 ☐ Divorced white Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Sewing Seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Page 1 and 2 should be fil tment of Health and Mental tant: If item 27 is marked ဂ္ Leah Markovich Israel Kesler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10502 Tuckerman Heights Circle, Rockville, MD 20852 Benjamin Ilkovich, Son 20b. Place of Disposition (Name of cemetery, crematory or other place)

Garden of Remembrance Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State Clarksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Porchinsky Hebrew Funeral Home 20012 254 Carroll St. . NW. Washington. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Priysician, mone Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Enter Linderlying Examine Due to (or as a consequence of): 1 Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death g 🗌 Unknown Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes has been signed 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes No page certificate 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 No Hospital Other: 1 Tes ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: Af 1 Yes 2 🗌 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of perso Linda 2 0 2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 42709 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month JOSEPH Ε. JENNETTE Jr. December 14,2011 11:10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Gaithersburg Wilson Health Care Center Social Security Number 6. Sex **Funeral** Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Hours April 24,1932 1 **X** M 2 □ F 79 228-36-1403 Virginia Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Gaithersburg Maryland Montgomery 1 X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 20877 United States 504 Russell Ave. filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 X Married 1 X Yes If Yes, Give 2 □ No 1951-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: "naturaf", White 1953 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Computer Science IBM Executive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 9 Evy Midgette Joseph Edward Jennette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1700 Pitt Place, Rockville, MD 20850 Kathryn Alsmeyer (Daughter) Date 15, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dec. 2011 cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crem. Alexandria, VA 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home (M01116)10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ dementia disease or condition resulting in death) Pars Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): e Hospital or Attending Physician: The law requires that the death certificate be executed be the charts after death.

24 hours after death.

Purparal Director. After this certificate has been signed by the attending physician and leted filled in by the furneral director, page 2 should be detached for use as the burial-figure. Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ဂ္ဂ 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manper of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State

Registrar

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within 2 To the 1

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only one

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16

29b. Signature and title certific

30. Name and address of person

even 31. Date filed (Month, Day, Year,

DEC

Box 68760

P.O.

Division of Vital

who completed cause of death (Item 233) (Type, Print

Olnsk

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Ave. Gzithershura

29d. Date signed (Month, Day, Year,

December

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Month Day Day 22 Physician/ Jody Lynn Jacques Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Smithsburg 13442 Station Lane g. Birthplace (State or Foreign ocial Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** July 30,1963 Hours 176-54-6400 Pennsylvania 48 Director 1 🗆 M 2 🗓 F Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Smithsburg 1 Yes 2 X No Maryland | Washington County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21783 13442 Station Lane 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 X Married Completed by White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Personal Residence Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Cecile J. Starliper James A. Angle 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13442 Station Lane Smithsburg, MD 21783 Walter C. Jacques-husband 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Ringgold Cemetery X Burial 2 Cremation 3 Removal from State 12-28-2011 Ringgold, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home Sign See of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, MD 21742 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury and that initiated events the burial-tra resulting in death) Last Due to (or as a consequence of) attending physician Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant 9 Unknown 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown the s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an funeral director, page 2 autopsy performed 1 Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 🗹 No ၉ 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify) after death.

Director: After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation the Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined 24 hours a Medical 1 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier pletely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2.

To the F the only one 29b. Signature and title of certifie 11667 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JW-6 Mack State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 237 PM **Physician** December 15 201 Marie Johnson onstance /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** hesterRiver hestertown Kent If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2 □ XF JULY 10, Director 182-01-3753 94 1917 PENNSYLVANIA Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show traumatic event, the Midical Examiner must be notified at 1 ☐ Yes 2 XNo Director OUEEN ANNE'S SUDLERSVILLE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò or items 23a 111 COLEMAN ROAD 21668 UNITED STATES Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2XNo Specify Specify: ģ 3 XWidowed 4 ☐ Divorced WHITE "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) 8 HOMEMAKER OWN HOME permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 is marked other t any Injury or other traumatic event, In 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ROBERT GILL MYRTLE N. YOUNG 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O. BOX 390 MILLINGTON, MARYLAND 21651 TIM JOHNSON / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 12/17/2011 | STEVENSVILLE, MARYLAND 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 21. Signature of Funeral Service License Kink S 21620 130 SPEÉR ROAD CHESTERTOWN, MARYLAND 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Heimers 640000 disease or condition resulting in death) /Medical Due to for as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month ρ in the past 12 months? 1 ☐ Yes 2 🗖 No Day Ye ar 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, <u>Ş</u> Arthritis: 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director, After this certifica director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 24 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No n 24 hours after death. le Funeral Director; A bletely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

.ης State

DHMH 17 Rev 1/2001

Registrar

institutoion MD 21620

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100 Brow

32. Registar's Signature

Neil Stoddard MD

31. Date filed (Month, Day

12/16/2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Sara Suber Jones December 19. 8:39 P. M 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring Holy Cross Hospital 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday, **Funeral** Days Hours Director 248-52-4323 85 1 🗌 M 2 🔀 F 02/06/1926 Whitmire,S.C. Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director XX Yes 2 No Washington D.C. 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 5 Funeral 23a 20019 U.S.A. 5817 Dix St., N.E. be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Black, White, etc. 0 þ 1 Never Married 2 Married Yes 2X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Black 3 Widowed 4 Divorced "natural" Completed traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Hygiene. Private Homes Domestic 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) f item 27 is mark-other ဂ္ Odell Suber Allean Reed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5817 Dix St., N.E., Washington, D.C. Johnnie I. Jones/Son injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or otl 1 XBurial 2 Cremation 3 Removal from State Ouantico Nat'l. Cem. | 12/28/11 Triangle, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Name and Address of Facility Henry S. Washington & Sons Co., Inc. ouce. auc rall Burroughs Ave., N.E., Washington, D.C. 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition Acute Coronary Syndrone Medical resulting in death) Due to (or as a consequence of): Examiner Cardiogenic Shock Sequentially list conditions Due to or as a conse puence of: cause. Enter Underlying Cause (Disease or injury that initiated events Acute Renal Failure the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) resulting in death) Last Certificate: To Be Completed by Physician/Medical Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performed? Yes 2 death? 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After 1 Natural injury | Natural | Accident | Suici 5 Pending work?
1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License numbe D65729 12/20/11

State Registrar 30. Name and address of person

Farzad Malckaninu, M.D. 1500 Forest Glen Road, Silver Sprin, Maryland 20910

ho completed cause of death (Item 23a) (Type, Print)

32. Registra 's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 03 2011 <u>Lillian Z. Jesano</u> December Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 9020 Paddock Ln Montgomery <u>Potomac</u> If Under 1 Year If Under 24 Hrs 6. Sex 8. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days 1 🗆 M 2 🗓 F Hours Director Yrs 177-07-8630 /15/1916 Pennsylvania 95 Usual Residence of Decede or 28a-f show notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 □ No MD Montgomery Potomac 5 10e. Street and Number 10f. Zip Code ms 23a or must be n 10g. Citizen of What Country? Funeral 9020 Paddock Ln 20854 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Examiner Black, White, etc. 5 þ 1 Never Married 2 Married 1 ☐ Yes 2 🏋 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" Specify 3 X Widowed 4 Divorced Completed Year or Dates White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filed tment of Health and Mental H tant: If item 27 is marked ot မ Harry Zoldan Grace Ackerman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) other t Garva Jesano / Daughter 9020 Paddock Ln. Potomac, MD 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State = 5 1 Burial 2 X Cremation 3 Removal from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 12/07/2011 National Falls Church, VA Crematory Signature of Funeral Service Licensee 22. Name and Address of Facility
Edward Sagel Funeral Direction Inc.
Blake 1091 Rockville Pike Rockville, MD 20 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Alzheimer's Disease disease or condition vears Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery in the past 12 months? Pregnant at time of death Yes 2 No 9 Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Q 1 ☐ Yes 2 🛛 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24a. Was an Were autopsy findings available prior to completion of cause of autopsv performed? death? certificate 1 ☐ Yes 2 ☐ No ompleted filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 X No Other: မ 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 \square Pending injury 1 Yes 2 No within 24 hours after death To the Funeral Director: A Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Limit Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practione: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Barry N.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Rosenbaum,

DEC 15 2011

D09834

3720 Farragut Ave. Kensington, MD 20895

December 07,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death I. Decedent's Name (First, Middle, Last) Day Month Physician/ 6:10 PM Prembe 2011 Kilpatric Mary Patricia Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Boonsboro Reeders Memorial Home If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) 6, Sex (Month, Day, Yes **Funeral** Days Min Year 1 □ M 2 🕱 F 74 Missouri **Director** 489-46-6541 Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10c. City, Town or Location 10a. State 10b. County with the Maryland the Medical Examiner must be notified at Director 1 X Yes 2 No Boonsboro Maryland Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral items 23a U.S.A. 21713 230 Potomac Street, Apartment 1C Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ō þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 5-0036 hours after 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced White Completed Year or Dates. 16b, Kind of Business Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72., h and Mental Hygiene.
7 is marked other than "r 72 Maryland 2121 College (1-4 or 5+) Elementary/Seconday (0-12) Library Administration <u>dministrative Assistant</u> permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other tany injury or other traumatic event, the Once. 6 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Josephine Geyer Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryland 21782 17204 Canal Road, Sharpsburg, Ross A. Kilpatric/Son timore, 20c. Location - City or Town, State 20a. Method of Disposition
1 □ Burial 2 X Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place 12/28/2011 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 22. Name and Address of Facility Bast-Stauffer Funeral Home, P.A. 21. Signature of Funeral Service Licensee 7606 Old National Pike, Boonsboro, Maryland 21713 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Interval Between
Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final EUURRENT Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Miservi. DEMONDERS DIMPRETES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Month in the past 12 months?

1 Yes 2 No Day 4 Pregnant a Unknown Pregnant at time of death Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 24 hours after death. Funeral Director: After this certificate has page 2 1 ☐ Yes 2 🌠 No 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) funeral director, Be Other: 4 M Nursing Home 5 Residence 6 Other (Specify) Hospital: ER/Outpatient 3 DOA မ 1 🗌 Inpatient 2 🗍 28a. Date of injury (Month, Day, Year) 28b. Time of Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 🔀 Natural 5 Pending 1 🗌 Yes 2 🗆 No Investigation Accident completed filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 □ within 2 To the I only one) Date signed (Month, Day, Year) 29b. Signature and title of certifier le 201

State Registrar

-5

Boonsboro, MD 21713 301-432-8470

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

.Ghazala

20311

32. P

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		•	For State Registrar	State of Ma	ar yrai iu		tificate of l		,	Reg. N	2011	42715	
	Physicia Medic		1. Decedent's Name (First, Middle, Las	Amy E	E. Ke	nned	У		2. Date of Dea Month Decemb		23, 2011	3. Time of Death 5:38 AM	
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Examin		4a. Facility Name (if not institution, give Brighton Garden	street and number)				r Location of Death mbia		40	County of Deat	h	
	Funeral Director		5. Social Security Number 6. Se	7. Age	(In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da November	th y, Year)	9. Bird Core 1923 Tak C	thplace (State or Foreign untry) oma Park, MD	
	show dat	tor	Usual Residence of Decedent 10a. State 10b. County		10c. City, 7							10d. Inside City Limits	
	ne Mary or 28a-f notified	Director	Maryland Howard 10e. Street and Number		Co	lumbi	a 10f. Zip Code			10a C	itizen of What Co	1 ☐ Yes 2 ☒ No	
	th with ti ns 23a o must be	Funeral	7110 Minstrel Way				2	1045		109. 0	USA		
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates.		"	Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2 🔼 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		14. Race - Ame Black, White Specify: USA	e, etc.	
215-(า 72 hou an "nat Medica	Completed	15. Decedent's E (Specify only highest gra			(Give I	lent's Usual Occup kind of work done O NOT use retired)	eation during most of work	king	I	Kind of Business	Industry	
121	d withir Hygiene ther th nt, the	a l	Elementary/Seconday (0-12) 12 17. Father's Name (First. Middle. Last)	College (1-4 of 5		Busi	iness Own	T	(F) 1 4 5 1 1 1		ennel		
ylanc	should be filed v h and Mental Hyg 7 is marked othe traumatic event,	To E	17. Father's Name (First, Middle, Last) Henry Clark 18. Mother's Name (First, Middle, Maiden Surname) Edith Garrison								Surname)		
, Mar	nd 2 shou ealth and m 27 is m		19a. Informant's Name/Relationship (T) Deborah Jean Goldbe				,	and Number or Run				o Code)	
Baltimore, Maryland	Page 1 alment of H tant: If itel		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif.		cem	netery, cren	sition (Name of natory or other place In Cemete	cy 12/2	Date 8/2011		ocation - City or	Town, State Maryland	
Ball	permit Depart Import any Inj once.		21. Signature of Funeral Service Licens	ee la	1-1		Name and Addre		ne, P.A.			more Avenue Le, MD 20781	
	Physician/		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	olications that caused ne cause on each line Alzheime			,	g, such as cardiac	or respiratory an	rest,		Approximate Interval Between Onset and Death 3 Years	
	Medical Examiner		resulting in death)	Due to (or as a	consequen	ice of):							
	red nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or lingery	Due to (or as a	consequen	ice of):							
	be executed sician and burial-transit	a	that initiated events resulting in death) Last	Due to (or as a	consequen	nce of):							
8760	tificate t ng physi as the b	Medic	IF FEMALE:	d									
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the but		ysician/I	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No g Unknown	23c. If yes, outcome of 1 Live Birth 1 Pregnant at g Unknown	2 🗌 Fetal d	leath 3 🗆	Ectopic pregnand Other (specify)	су			23d. Date of del Month	livery Day Year
, P.O.	requires that the de been signed by the should be detached	by	Part II. Other significant conditions co	entributing to death bu	ut not resulti	ing in the u	nderlying cause gi	ven in Part I.			_	the cause of death?	
ords	w requir s been s 2 should	Completed							24a. Was	an	24b. Were aut	topsy findings available	
Rec	sician: The law certificate has rector, page 2		OF War						1 Yes	rmed?	death?	completion of cause of	
Vita	hysician:] nis certifica director, p	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1	nt 2 🗆 EF	 NOutpatien	26. Pl	ace of Death <i>(Ch</i> ece er: 4 □ Nursing H	1/2	dence (6 🛛 Other (Spec	Assisted Living	
on of	nding Phy ath. * After this e funeral o	icate:	27. Manner of Death 1 🛣 Natural 5 🗌 Pending 2 🔲 Accident Investigation	28a. Date of injur (Month, Day)		3b. Time of injury	work	yat ⟨? Yes 2 ☐ No	28d. Describe h	iow injui	ry occurred		
Division of Vital Records,	ial or Attenders after deatland Director.	l Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homlcide determined	28e. Place of Inju building, etc	ry - At home . (Specify)	e, farm, stre	eet, factory, office		28f. Location (S City or Tow			ral Route Number,	
	To the Hospital continuity of the Funeral D completed filled in	Medical	29a. Certifier 1	ician: To the best of r ner: On the basis of ex e Practioner: To the b	amination ar	nd/or invest	igation, in my opinie	on, death occurred a	t the time, date a	nd place	e, and due to the o	cause(s) and manner stated.	
	To t To t		29b. Signature and title of certifier	4	m.	D .	29c. Licens	D56531		29d. Da	ate signed (Month		
2	5		30. Name and address of person who c)1, Colum	bia, MD	210	45		
I	Stat	е	31, Date filed (Month, Day Year)	32. Registry									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Time of Death 2. Date of Death Physician/ ICERN ARY 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Tate Chesapeake Hospice House Linthicum Anne Arundel 5. Social Security Numbe Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days (Month, Day, Year) 218-12-6945 88 Director 1 DM 2 ZF May 16,1923 Maryland Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director MD Anne Arundel Severna Park 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 41 Snellings Court 21146 USA ould be filed within 72 hours after death vod Mental Hygiene.
marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 **X** No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian þ 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced Specify Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Cuddy Barbara McAlevy Jet 1 and 2 sh.
Jepartment of Health and Important: If item 27 is many injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 41 Snellings Court Severna Park, MD 21146 Mary Jo Duvall / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Dec. 15, 20c. Location - City or Town, State 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place)
Cedar Hill Cemetery Brooklyn Park, MD 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home
495 Ritchie Hwy, Severna Park, MD 21146 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart latture. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final STROKE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) nding physician Physician/Medical death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by EMENTIA Records, Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performer 1 Yes Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide work? 1 Yes 2 No Investigation 6 Could not be filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier 29c. License number 21438 TU W Name and address of person who completed cause of death (Item 23a) (Type, Print) OW 445 DEFENSE HWY ANNAPOLIS MD 21401 State **DEC 192011** Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1/2 1/2 1/2 1 1 3. Time of Death 2:35a M Physician/ Kathryn Klett Anna Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death . County of Death Montgomery **Examiner** Brooke Grove Rehab & Nursing Sandy Spring Social Security Number 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8 Date of Birth **Funeral** 877077 1919 188-05-9763 92 Director 1 □ M 2 🕇 F Usual Residence of Decedent 10a State 10c. City. Town or Location 10d. Inside City Limits at the Maryland Director MD Sandy Spring must be notified Montgomery 28a-f 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ö Slade School Road 23a Funeral 20860 18131 USA with items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, ıral", or iten Examiner r Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black. White, etc. ģ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after 3altimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify. "natural" Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the School Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H

27 is marked ot

traumatic ever ၉ Ida Groh Jacob O. Lentz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t; If item 27 is 1913 Morningmist Drive Silver Spring, Md Karl K. Klett Jr./Son 20a. Method of Disposition 12/2ale/2011 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Department of Important; If any injury or Lebanon, PA. Mt.Lebanon Cemetery 4 Donation 5 Other (Specify) 21. Signature of PHIT TPADSREMALDI FUNERAL SERVICE, P.A 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final President Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events the buristmans and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown φ Day Month Year Pregnant at time of death be detached the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ hypertension, dementia, peripheral vascular 1 Yes 2 No 3 Probably 4 Unknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? disease, chronic obstructive pulmonary page 2 has autopsy performed Yes 2 or Attending Physician: The after death.

Director: After this certificate by disease, sick sinus syndrome 1 Yes 2 No Yes 25. Was case referred to medical funeral director, Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 🔀 Nursing Home 5 🗌 Residence 6 🗍 Other (Specify) ER/Outpatient 3 DOA 1 Inpatient 2 27. Manner of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral D Medical **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie DOO 57630 10 of death (Item 23a) (Type, Print) 10301 Georgia Ave #209 Silver Spring, Md 20902

Registrar

State

30. Name and address of person who completed cause of Anuradha Arun M.D.

1 9 2011

31. Date filed (Month, Day, Year)

barked

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Valla Wax FT	IIICE	1- For State Certific	nent of Health and Mental Hy cate of Death	ygiene Reg. 1	2011 4271
Physi		Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death	3. Time of Death
ledical Exam	nine	EVANS MAX PRINCE KWAMLA 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	Month Da December 12	
		W/B Clara Barton Pkwy	Bethesda		4c. County of Death Montgomery
Funera		Social Security Number 6. Sex 7. Age (In yrs. last bi		8. Date of Birth(N	MM/DD/YYYY) 9. Birthplace (State or
Directo	T	127-88-0385 1∑M 2□F 60	Yrs. Months Days Hours Min.	2-13-19 10/13/1	951 Foreign Country) Ghana
, any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	n or Location		10d. Inside City Limits
	<u>ا</u> ا	MD Montgomery German	town		1 XYes 2 No
Maryland	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
th the P		18915 Porterfield Way	20874		ana
ath wit	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 		 Race - American Indian, Black, White, etc.
fter de	1 P	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Yeer	1 Yes 2 No specify:		Specify: Black
nours a	A De		Decedent's Usual Occupation (Give kind of videring most of working life, DO NOT use retired.)		b. Kind of Business/Industry
36 iin 72	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)			Tema Danat
ed with		17. Father's Name (First, Middle, Last)	ccountant 18.Mother's Name	(First, Middle, Maid	Home Depot den Surname)
21215-0036 void be filed within 7 Mental Hygiene. marked other than	Be Li	Timothy Kwamla	Annie Fr		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho	2		9b. Mailing Address (Street and Number or F		
e, M and 2 Health item 2		20a. Method of Disposition 20b. Place	18915 Porterfield Way of Disposition (Name of cemetery,		COWIT, PID 20074 Oc. Location - City or Town, State
nor Pages 1 ent of H		The same of the sa	atory or other place) Church Cemetery 02/	/04/2012 : 2.102/201	Accura, Ghana
Baltimore, permit. Pages lar Department of Hee	ń.	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Sno	wden Fun	eral Home
		George Hund	246 N. Washington		
Physicia /Medica		23a. Part I. Enter the disease, or complications that caused the death. Do r failure. List only one cause on each line.	not enter the mode of dying, such as cardiac o	r respiratory arrest,	shock, or heart Approximate Interval 8etween Onset and Death
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		Sequentially list conditions, b			
	xaminer	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated			
3 B		events resulting in death) Last Due to (or as a consequence of):			
Box 68760, e death certificate be executed the attending physician and	Physician/Medical Ex	d. UNPENDED #8perTNF,12/29/11;B			
760, cate bo	Mec	IF FEMALE: 23c. If yes, outcome of pregnance	<u>MW,M0C0</u>		23d. Date of delivery
Box 68760, e death certificate b	cian	past 12 months?	2 Fetal death 3 Ectopic pregna 5 Other (Specify)	incy .	Month Day Year
that the death	hysi	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)		
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ds, equires	eted Steel			24a. Was an	24b. Were autopsy findings available
tal Records.	Completed			autopsy performe	
I Re		25. Was case referred to medical	26.Place of Death (Check		No 1 ✓ Yes 2 No
Vita hysicia this ce	5 I o	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/0	IOther —		sidence 6 🗸 Other: \$cene
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici.	Din:	1 Natural Do (Month, Day, Yeer)	. Time of Injury 28c. Injury at Work?	28d. Describe how Passenger aut	rinjury occurred to fixed object collision
Atten Atten r death	cati	2 Accident Investigation 28e Place of Injury - At home	JZ nrs 1 Yes 2 ✓ No farm, street, factory, office building, etc.	29f Location (Stre	eet and Number or Rural Route Number, City
Division of Divisi	Certification:	Suicide 6 Could not be determined (Specify) Local Street	raini, stroot, ractory, onlos building, etc.	or Town, State	
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director:		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	eath occurred at the time, date and place, and	due to the cause(s) and manner as stated.
To the within To the	Medical	one) 2 Medical Examiner: On the basis of examination and/or and manner stated. 29b. Signature and title of certifier			
ale	2	255. Signature and little of certifier	29c. License number O.C.M.E.		9d. Date signed (Month, Day, Year) December 12, 2011
		30. Name and address of person who completed cause of death (Item 23a)			
		Ling Li, MD Assistant Medical Examiner 900 W. I	Baltimore Street, Baltimore, MD 21	223	
	State istra		parle		

DHMH 17 Rev 1/2001 OCME 2006 8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December CHARLES KIRK Α. 13, 2011 6:00 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Casey House-Montgomery Hospice Derwood 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Hours 217-44-5259 64 1 🛣 M 2 🗆 F Director Feb. 23,1947 Washington D.C. Usual Residence of Decedent 28a-f show 10a, State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified 1 X Yes 2 No Maryland| Montgomery Gaithersburg 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 9 must be 20877 Funeral 23a 451 Sternwheeler Court United States items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Examiner Black, White, etc. ö þ 1 Never Married 2 X Married 1 X Yes 2 □ No If Yes, Give Vietnam Year or Dates. permit. Page 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiens. Intropretant: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinant in Jury or other traumatic event, the Medical Examinant is any injury or other traumatic event, the Medical Examinant is any injury or other traumatic event, the Medical Examinant is any injury or other traumatic event. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Giant Food Stores Meat Cutter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thelma Bell Albert Kirk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod Sternwheeler Court, Gaithersburg, MD 20877 Maya Kirk (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Alexandria, VA Metropolitan Crem. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility DeVol Funeral Home . De (M01116)10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Bladder Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or minuty Examine Due to (or as a consequence of): tans executed Cause (Disease or injurthat initiated events resulting in death) Last and Due to (or as a consequence of): burialattending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death the s 1 ☐ Yes 2 ☐ Unknown s been signed by the should be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 2 🗌 No 1 Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 XOther (Specify) Hospice 2 🗓 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work?
1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

State Registrar DHMH 17 Rev 06-2011

pletely

29a. Certifier

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Yea

Debra Miller CRNP

DEC 15

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signa

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

R143201

29d. Date signed (Month, Day, Year,

20855

12

29c. License number

6001 Muncaster Mill Road; Rockville, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 13, Physician/ Month December 4:30 pm Bella Briansky Kalter Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Suburban Hospital Bethesda Social Security Number Birthplace (State or Foreign Country) Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Month, Day, Yes Months Days Min Poland Director 296-74-9642 90 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director ms 23a or 28a-f s must be notified Rockville 1 Yes 2 X No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20852 U.S.A. & Canada 1801 E. Jefferson Street, 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married Completed by 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: White Year or Dates item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Health and Mental Hygiene. Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Chava Goldstock Pinchas Briansky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eliot Kalter - Son 7210 Pyle Road. Bethesda. Maryland 20817 t: If item 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 C Removal from State Judean Memorial Grdns 12/15/2011 Olney. Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 21. Signature of Funeral Service 1100709 M. 23a. Part 1. Enter the tisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hea 4.9 liure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Carbon Dioxide Retention Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Kater, Be/laDivision of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo Month Year 5 Other (specify) Pregnant at time of death To the Hospital or Attending Physician: The law requires that the deswithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Restrictive Lung Disease, Obstructive Lung Disease, 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 🗓 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Kyphascoliosis, Large Hiatal Hernia, Aortic autopsy performed? Stenosis Yes 2 X No 25. Was case referred to medical examiner?

1 Yes 2 XNo Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🗶 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature 29d. Date signed (Month, Day, Year) December 13, 2011 D72726 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road, Bethesda, Maryland Lori Pihl, M.D., 31. Date filed (Month, Day, Year) **IEC 1** 5 2011 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 11, 2011 Physician/ 9:00 Leona Ida Keim Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Citizens Care & Rehab Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Dec. 5, 1915 . Social Security Number , Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🛣 F Months Days Hours Iowa" 96 478-12-0578 Director Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director Frederick Maryland Frederick 1 X Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21702 Funeral United States 355 Montevue Lane Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. 1 Never Married 2 Married 9 Baltimore, Maryland 21215-0036 Specify:White 1 ☐ Yes 2 X No Specify. If Ves Give 3 K Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna Specht John Kroll 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Loerich /Daughter-in-21547 Mt. Aetna Rd., Hagerstown, MD 21742 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Dec. 15 2011 Resthayen Memorial Gardens 1

■ Burial 2

□ Cremation 3

□ Removal from State Frederick, Maryland 4 Donation 5 Other (Specify) Signature uneral S Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, MD 21701 or, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. 23a. Part 1. Phiter the dis shock, or heart fail Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EUMONIA -Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and
To the Funeral Director. After this certificate has been signed by the attending physician and that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Tunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🖪 No ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Medical Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title D006/410

Registrar
DHMH 17 Rev 7/2009

State

801

32. Registrar's Signature

TOLL HOUSE HY, FREDERICK, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 5 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 76, 2011 Eleanor Lee Lovell 5:12 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months **Director** 040-32-7759 1 □ M 2**X** F 71 July 11,1940 Connecticut or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 ☐ No Maryland | Anne Arundel Annapolis 10e. Street and Number 10g. Citizen of What Country? ō "natural", or items 23a o Funeral 21403 United States 53 Gentry Court permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. Yes 2 X No 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed er than "natur , the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Ith and Mental Hygiene. 27 is marked other than r traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Veterans Administration 5+ Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Eleanor Underwood Osborn Willard Ladd Lovell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Colleen C. Mawicke/Personal Rep. 819 Oak Grove Circle, Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/19/2011 Baltimore, Maryland Baltimore Crematory 21 Signature of Funeral Service 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ schemic disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of). Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 5 Other (specify) Pregnant at time of death should be detached ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 perform after death.

Director: After this certificate 2 🗌 No Yes 2 No 1 🗌 Yes funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗆 Yes 2 🗆 No the Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar DEC 19 2011

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

LOUI

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Charlotte Selheim December 2011 10:43 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Asbury Solomons Skilled Nursing Ctr Calvert Solomons Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jun 26, 1919 7. Age (In yrs. last birthday) g. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F Days Towa **Director** 483-14-6401 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No MD Calvert Solomons 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11750 Asbury Circle 20688 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc ō ģ ☐ Yes 2 X No 1 Never Married 2 Married Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural", Specify Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working alth and Mental Hygiene.

127 is marked other than "I ar traumatic event, the Mec life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Selheim Klaus Senova Blomda1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains Eugene Long - Son 214 Derby Park Avenue New Bern, NC Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Lee Crematory 12/20/2011 4 ☐ Donation 5 ☐ Other (Specify) Clinton, MD Signature of Funeral Service Licer Lee Funeral Home Calvert, 22. Name and Address of Facility Gary J. Goff 8200 Jennifer Lane Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ a. COM/LICATIONSOF ATHEROSCLERUTIC CARDIOVASCULAR DISEASE FARS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to for as a consecuence on dany, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the at d be detached for g 🗌 Unknown Hospital or Attending Physician: The law requires that the 24 hours after death.
 Funeral Director: After this certificate has been signed by th Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HAPERUIPIDEM Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has performed 1 Yes 2 No funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 10 Other: 4 Kursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 40 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending
Investigation injury 2 ☐ Accident 3 ☐ Suicide the 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 263,58 20,201,

State

Registrar

20 15

10845 Town Center Blvd.

Registrar's Signature

Clevena

Dunkirk, MD

20754

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yohn H. Weigel, MD

NFC

31. Date filed (Month, Day, Year)

Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records,

within 24 hours after death.

To the Funeral Director: After this certific Completely filled in by the funeral director, Certification: To (Xcritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

State Registrar

10810 Darnestown Road, #202, Gaithersburg, MD 20878

31. Date filed (Month, Day, Year) DEC 2 0 2011

Raman R. Tuli, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32, Registrar's Signature

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	Examir		^{4a.} Facility Nam <i>e (if</i> Suburban			number)			4b. City, Be	Town, or	Location da	of Death			c County	of Death	у	
	Funeral Director		5. Social Security N 213-30-4		6. Sex			ast birthday)	If Under Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da)	9. Birth Cou		e or Foreign
		L	Usual Residence		1 G M 2 G		79 Lana Cit	Yrs.	nation				08/27/	193	2	Mary	land	City Limits
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	with the N 23a or 2 ust be no	Funeral Di	10e. Street and Nur 912 Isla		se Sea (Color	ny	2. ***	10f. Zip	9930				10g. Citizen of What Co United Sta				
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Mavyland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. and another than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed		ried Armed 1 X Y If Yes,	Forces?	No 19.	55-	Was Decedent of Hispanic Origin? (Specify Yes of Yes, specify Cuban, Mexican, Puerto Rican, etc □ Yes 2 ▼No Specify:			cify Yes or No- Rican, etc.)	-	14. Race - American Indian, Black, White, etc. Specify: White				
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Baltimore, Maryland 21215-0036	l be filed with lental Hygier rked other t lic event, th	45		mentary/Secondary (0-12) College (1-4 or 5+) ther's Name (First, Middle, Last) harles S. H. Lockman						18. Mother's Name (First, Middle, Ma Sadie Durst								
, Mary	and 2 should Health and N tem 27 is ma ther trauma		19a. Informant's Na Jacquelin	ne L. L		' Wif	e	19b. Mailii 912	ng Address Islar	s (Street a	ouse	er or Rura Sea	I Route Numbe	er, City o	or Town, S than	itate, Zip y Bea	Code) 1	9930 DE
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Balt	permit Depart Import any inj once,		21. Signature	eral Service L	icensee	,							eph Gaw . NW Wa					16
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	Medical Examiner		resulting in death)				a consequ		rrita	<u> </u>	P		. \	~	MO	124		
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09.	cate be executed physician and s the burianteesit	I= I	resulting in death)		d	to (or as a consequence of):						13	, /,					
. Box 68760	certifi nding use a	Physician/Medica								☐ Ectopic pregnancy ☐ Other (specify)					23d. Da Mo	te of deli	very Day	Year
ls, P.0	requires that the death been signed by the atte should be detached for	by	Part II. Other signif						ınderlying (cause giv	en in Part	1.					the cause o	of death?
Division of Vital Records, P.O.	ysician: The law req is certificate has bee director, page 2 sho	Completed		_									24a. Was auto perfo 1 \square Yes			prior to c death?		gs available of cause of
Vital	ysician: The is certificate be director, page	To Be	25. Was case referrex examiner? 1 X Yes 2	_	Hospital:	XInnati	ent 2 🗆	ER/Outpatie	nt 3 🗆 D0	-	ace of Dea		only one) me 5 ☐ Resi	idence	6 □ Othe	er (Specii	fv)	
on of	nding Phy ath. r: After this	Certificate: T	27. Manner of Deat 1 Natural 2 Accident	h 5 🗌 Pendir Investi	28a. Da	ate of injudenth, Da 008/2	ry	28b. Time of injury 7:00	1 2	8c. Injury work	at at	1	28d. Describe	how inj	ury occurr	ed		h
Division	ospital or Attending Ph hours after death. neral Director: After thi y filled in by the funeral		3 ☐ Suicide 4 ☐ Homicide	6 U Could determ	. 1286 PI	ace of Injuding, etc	ury - At ho c. (Specify	ome, farm, str	eet, factory	y, office		1.0	28f. Location (City or To	wii, ola	(0)			
	ithin 24 hours The Funeral	Medical	(Check 2	Medical E	Physician: To the xaminer: On the Nurse Practitio	basis of e	examination	n and/or inves	tigation, in i	my opinio	n, death o	ccurred at	the time, date	and pla	ce, and due	e to the c	ause(s) and	manner state
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'Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Medic Examin				give street and number)			4b. City. Toy	vn. or I	Location of Dea			10 Z		110.00 p M	
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and show i at	ō	10a. State	10b. County		10c. Cit	City, Town or Location								10d. Inside City Limits	
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er dea or ite niner	by F	11. Marital Status1 ☐ Never Marr	ied 2 🗆 Marrie	12. Was Decedent Armed Forces ed 1 Yes 2			13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)				D. G. G. T. T. T. T. T. T. T. T. T. T. T. T. T.			etc.	
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d be f Venta arked atic ev	၉	Wilford	Charles	s Curry					Evelyn	Windso	r				
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Na	me/Relationshi	p (Type, Print) Daughter		19b. Mailin	g Address (St	treet ar	nd Number or R Lane, S	ural Route Num	ber, City	or Town, S	tate, Zip	Code)	
and 2 Health em 27 ther to		20a. Method of Disp			Look I	Place of Dispos			tane, a		-				
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Physician/		Immediate Cause (disease or condition	Final	a Chronic		ructiv	e Pulm	ona	rv Dise	25 6			1	Onset and Death	
Medical Examiner		resulting in death)	1	Due to (or as	a conseq	uence of):			- J						
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siciar certif lirecto	Be C	25. Was case referrence examiner? 1 ☐ Yes 2 ₹	ed to medical No	Hospital:		15000		Other	ce of Death (Ch				-		
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eath. or: Aftu	ficat	1X Natural 2 Accident	5 Pending Investiga	ation	ay, rear)	injury		work?	∕es 2□No						
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bu		On Cartifian 1	X Carrierina	Physician: To the best o	f my lengue	lodge death a	and the	o timo	data and wlass	and due to the	200100(0)	and mann	or on otat	tod	
e Hos 24 h e Fun	Medical	(Check 2	Medical Ex	caminer: On the basis of Nurse Practitioner: To t	examinatio	n and/or invest	igation, in my	opinion	n, death occurred	d at the time, da	te and plac	ce, and due	to the ca	use(s) and manner stated	
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Suzanne LIFSCHITZ **Physician** 14, 2011 10:59 A December /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Rockville

Winder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 1799 E. Jefferson St., #209 Montgomery Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year Months Days 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 □ XF 90 579-50-0295 Yrs. Jan. 31, 1921 Director Egypt Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits the Maryland 10b. County 10a. State or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Rockville Maryland Montgomery Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20852 United States 1799 E. Jefferson St., #209 Items 23a Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 ☑ No Specify: Specify: white by 3 ♥ Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Dry Cleaners **Owner** permit. Pages 1 and 2 should be filled witl Department of Heatth and Mental Hygiene Important: If Itam 27 Is marked other the any injury or other traumatic avant, I'm QRC8. 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Joseph Scheinin Miriam Vilder 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15303 Diamond Cove Terr., #F, Rockville, MD 20850 Naomi Levy, Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Lebanon Cemetery | 12/16/11 4 ☐ Donation 5 ☐ Other (Specify) Adelphi, MD 21. Sign ture of superal service Licensee TorchinskyssHebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 Approximate Interval Between Onset and Death 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final End Stage Cardiomy opathy Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Completed by Physician/MedIcal IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown pertension 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy has 2 X No 1 Yes filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Assisted Hospital: 1 Inpatient Other: 4 Nursing Home 2**X**410 2 ER/Outpatient 3 DOA 5 🗌 Residence 6 Other (Specify) 1 🗌 Yes Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death ☐ Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a To the Funaral C Hospital Excertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 D69568 WD 12

State Registrar 31. Date filed (Month, Day, Year) DEC 15 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1801 E Jefferson Steet Rockville MD 20852 A. Chilakamarn, MD 32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) December 11.2011 Physician/ David James Liu 0247 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Montgomery General Hospital Olney Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Days **Director** 576-24-1547 1 🛛 XM 2 🗆 F 81 May 29, 1930 Hawaii Usual Residence of Decedent 10d: Inside City Limits 28a-f show 10c. City, Town or Location of Health and Mental Hygiene. item 23a or 28a-f shoritem 27 is marked other than "natural", or items 23a or 28a-f shoother traumatic event, the Medical Examiner must be notified at 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Olney Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 20832 U.S.A 19409 Charline Manor Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 X Yes 2 No Black, White, etc 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Asian Specify 3 Divorced Completed Korea Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Education Elementary School Teacher 5+ Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Violet Lau Ah Ming Liu 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19409 Charline Manor Road, Olney, Maryland 20832 of Health Carol Liu - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Important: If it any injury or o 💢 Burial 2 🗌 Cremation 3 🗌 Removal from State Rockville, Maryland Parklawn Mem. Grdns. 12/16/2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. of Fun ral is rvice Li Signa 11800 New Hampshire Ave., Silver Spring, MD 20904 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cardiovies wellen Physician/ Atherona levotro resulting in death) Medical **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence or) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ig physician and as the burial traes Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Yes 2 No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Dinbetes 24b. Were autopsy findings available Hypertension 24a. Was an prior to completion of cause of death? autopsy performed Dyslipidamia 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 FR/Outpatient 3 IDOA ပ 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Medical Certificate: 1 Natural 5 Pending 2 🗌 No Accident Investigation within 24 hours after death

To the Funeral Director; A
completely filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 039743 Dreember 12, 2011 541

State Registrar 31. Date filed (Month, Day, Year)

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Christopher J. Mays, MA 18111 Prince Philip Doive, Olney, MB 20032

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend 24a&26 per med cert 6923 1/12/12 dk
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 19, 2011 Physician/ Jack A. Lawrence 12:00 A M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Prince George's 3148 Gracefield Road. Apt Silver Spring Age (In yrs. last birthday) If Under 24 H 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1√2 M 2 □ F Days Months Hours Dec 14 Year 926 Country) Illinois 85 334-20-9922 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland items 23a or 28a-f sho ter must be notified at rector 1 🗆 Yes 2 🖺 No Prince George's M Silver Spring ō 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 3148 Gracefield Road 20904 <u> United States</u> Apt CL622 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-"natural", or item ledical Examiner n 14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican. etc.) Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 ANo Specify: Specify: White If Yes Give 3 Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry National Security and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Agency Cryptographer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve 2 Roland Cecil Lawrence Lucile Oale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3148 Gracefield Rd, Apt CL622 Silver Spring, MD 20904 Marcheta L. Lawrence/wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Ardent Cremation Svc 1 Burial 2 X Cremation 3 Removal from State Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 12/20/2011 22. Name and Address of Facility Harry H. Witzke's Family FII, Inc. 21. Signature of Funeral Service Ligen any in once, Homa 4112 Old Columbia Pike Ellicott City, MD 21043 uanita 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 5 years Immediate Cause (Final Physician Chronic Obstructive Pulmonary Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to or as a consequence of If any leading to immedia cause. Enter Underlying -transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the burla Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Box Į Į in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death signed by the a d be detached f Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? has certificate 1 ☐ Yes 2 ☐ No Yes 2 No or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director. 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ည 27. Manner of Death

1 Natural
2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work'? 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 29b, Signature and title D24093 December 19, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark Parkhurst, M.D. 3110 Gracefield Road Silver Spring, Maryland 20904 31. Date filed (Month) 32. Registrar's Signature State Registrar

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24a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 201 Mower Charles Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Allegany WMHS-RMC Cumberland 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Birthpia Country) MD **Funeral** Jan 18, 1924 Months Hours Min **Director** 1 XM 2 □ F 217-18-4902 87 Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director Cumberland 28a-f MD Allegany 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 21502 USA 12510 McMullen Hwy death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. Examiner Armed Force Black, White, etc. þ 2 No permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates WW II 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) C & P Telephone Co. lineman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Genevieve E. Sherry Charles M. Mower 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, MD 21502 Jill Brooks 702 Frederick Street Cumberland per. rep 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 1/2/2012 Hillcrest Memorial Park MD Cumberland Donation 5 Oher (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA ignatu of Funeral Se 108 Virginia Avenue: Cumberland, MD 21502 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ OCA disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine Due to for as a consequence of If any, leading to immedia cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ Live Birth 2 Li Fetal Gea Pregnant at time of death in the past 12 months?

1 Yes 2 No Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certificate: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated United Territaling Aurise Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

625

Do0 33280

Ave. Ste 101 Cumberland Mi

		For State Registrar 1. Decedent's Name (F	First, Middle, L	ast)		Cer	tificate of L	Death		2. Date of Death		U I	3. Time of Death	
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amine		4a. Facility Name (if no 950) 5. Social Security Num	ot institution, g	Oak D	nber)	4b. City, Town, or Location of Death Silver Spring, M(rs. last birthday) If Under 1 Year If Under 24 Hrs.				8. Date of Birth	4c. Count	lant	th Gonery Walace (State of Foreig	
eral etor		226-46-759 Usual Residence of D	92	1 🛣 M 2 □ F	7. Age (m yrs. n	Yrs.	Months Days Hours Min. (Month, Day, Year) Jan. 18, 1939					Co	ashington,	
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notifie	Director	MD 10e. Street and Number		gomery		Silve:	r Spring			10g. Citizen of What Co			1 Yes 2X	
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	d by Funeral	11. Marital Status 1 Never Married 3 Widowed 4		Armed Fo	e	U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes- If Yes, specify Cuban, Mexican, Puerto Rican, et 1 ☐ Yes 2 ⚠ No Specify:					or No- 14. Race - American India			
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ny inji	Ì	21. Signature of Funer	ral Service Lice	ensee	_	Į.	Name and Addres	ss of Facilit			Home	Inc.	g, MD 2091	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death Month 12 Physician/ Frances 0510AM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** . Health Case Facility Haberstown Washington Julia Manoa If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number . Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 11-7-1924 $\stackrel{Country)}{ ext{MD}}$ 215-20-9089 87 1 □ M 2**X** F **Director** Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director MD Washington Hagerstown 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 0 must be i 333 Mill Street 21740 Funeral U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2X No ian "natural", or iter Medical Examiner Black, White, etc white Specify: 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 filed within 72 hours after 1 Yes 2 X No Specify. If Yes, Give Year or Dates 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry public school permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) Cafeteria Assistant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Francis Kreigh Alice Ottie Boward 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1232 Glenwood Ave. Hagerstown, MD 21742 19a. Informant's Name/Relationship (Type, Print)
Sidney B.Mills son 20c. Location - City or 10win, Scale Clear Spring, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 12-230cemetery, crematory or other place)
St.Paul Cemetery 1 XBurial 2 Cremation 3 Removal from State 2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Donald Edwin Thompson Funeral Home, Inc Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. attlin Interval Between Onset and Death Immediate Cause (Final Physician ascular disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Hypertensive The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ the atter in the past 12 months?
1 ☐ Yes 2 ☒ No Pregnant at time of death g 🗌 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypothyroidism, Osteoarthritis, Seizure Disonter 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Dysphacia, Osteoporosis autopsy performed? Yes 2 No has 1 Yes 2 No certificate To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 ☐ Yes 2 🕱 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: After t 1 X Natural 5 Pending 1 Yes 2 No within 24 hours after death

To the Funeral Director: A
completely filled in by the f 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number R125360 2011

JW-10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2<u>011</u> Month Dec. Physician/ Teresa Florence Mather 22, 9:00 A Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 11374 Cherry Hill Rd, #301 Prince George's Beltsville 8. Date of Birth
(Month, Day, Yea
May 10, 1 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In yrs. last birthday **Funeral** Min. 1 □ M 2 🖾 F Days Hours 85 1926 Waterville, ME Director 006-20-1101 Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland notified at Director 28a-f Prince George's Beltsville 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ or than "natural", or items 23a or the Medical Examiner must be Funeral 20705 USA 11374 Cherry Hill Rd, #301 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc ģ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir Baltimore, Maryland 21215-0036 White 1 Yes 2x No Specify: If Yes, Give Specify: Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Office Supply 8 Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Marie Louise Fortin Thomas Labonte 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11374 Cherry Hill Rd, #303, Beltsville, MD 20705 Wanda A. Reyes - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State 12/24/2011 Alexandria, Virginia 4 Donation 5 Other (Specify) Metropolitan Crematory 4739 Baltimore Ave. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Þ Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death been signed by the s should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 No grenist 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perform 1 Yes 2 No Yes 2X No 25. Was case referred to medical director. 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury 5 Pending 1 X Natural work? 1 ☐ Yes 2 ☐ No

or Attending Physician: The law requires that the death certificate be Division of Vital Records. within 24 hours after death.

To the Funeral Director: After this the Hospital

State Registrar

Medical

Accident

Suicide

4 Homicide

only one

29a. Certifier

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Confifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Investigation

Could not be

determined

6 🗌

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Belai Berhe Medhin 9:35 2011 Рм December Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Bethesda Nursing & Rehab Center Montgomery Bethesda 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 - F Months Hours 208-70-7897 79 **Director** Ethiopia May Usual Residence of Decedent 28a-f shov ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director DC 1 X Yes 2 ☐ No Washington 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 3298 Fort Lincoln Drive, #330 20018 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. ò 1 Never Married 2 X Married 72 hours after Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Pharmacy Industry Pharmacist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Berhe Medhin Gezachen Tedla other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 3298 Fort Lincoln Drive, #330, Washington, DC 20018 Tsehaitu Hadera / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 5 1 X Burial 2 Cremation 3 Removal from State injuny Fort Lincoln Cemetery 12/29/2011 Brentwood, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 as Gasch's Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final HEPATITIS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of): that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Dav Year 5 Other (specify) Yes 2 No 9 Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be or Attending Physician; The law requires Completed 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform this certificate 1 ☐ Yes 2 PNo director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 1 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 27. Manger of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After (Month, Day, Year) Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my paining Medical 29a, Certifier completed 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Wan, MD

State

Registrar DHMH 17 Rev 7/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra

Truong Bao, M.D.,

72011

31. Date filed (Month,

DEC 2

DOOT

10110 Molecular Drive, Rockville, MD 20850

12/23/11

AACO Health Dept. 12-19-11 KAH State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ERTRUDE Medical 0315M 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 921 Madison Street Annapolis Anne Arundel . Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Months Director Hours (Month, Day, Year) 215-40-7792 1 M 2 F 94 Vrc Nov. 11,1917 Baltimore, MD 28a-f show 10a. State notified at 10b. County Director 10c. City. Town or Location 10d. Inside City Limits Maryland | Anne Arundel Annapolis 1 Yes 2 No 10e. Street and Number ò 10f. Zip Code must be 10g. Citizen of What Country? 23a Funeral 921 Madison Street 21403 United States 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian Armed Force by 1 Never Married 2 Married Yes 2 X No Black, White, etc. Baltimore, Maryland 21215-0036 If Yes, Give Completed 1 ☐ Yes 2 No Specify: 3 🙀 Widowed 4 🗌 Divorced Year or Dates Specify: White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve and Mental Thomas Everett Grierson Christina Goetz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code)
6129 Eldorado Rd. Thodesdale, MD 21654 2165 Thomas J. Miller, Jr Son MD 21654 21659 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Mem.Gardens 12/19/2011 Annapolis, MD Signature of Funeral Service License 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. once. 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part \ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician/ Sheet and Death CUTE ESPIRATORY Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) that initiated events resulting in death) Last burial-Due to (or as a consequence of): physician Be Completed by Physician/Medical Box 68760 as attending nse 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery Ď 3 🔲 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month Day the 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, completely filled in by the funeral director, page 2 should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed the Hospital or Attending Physician: The 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ျှ Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) After 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No death hin 24 hours after death the Funeral Director; Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a Certifier Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check ပို 29b Signature and title of Bertifier State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 06-2011

Amend #19 a,b per FD

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Physicia			OTH		P		Me.	EINE	2-		2. Date of De Month	D		/ear	3. Time of Death
Medic Examine		4a. Facility Name (if			nd number)		110	4b. City, Town, or		of Death	1.7.7	<u> </u>	. County of	Death	1770
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Funeral Director		5. Social Security N 216-24-9		6. Sex 1 ☐ M 2		e (In yrs. I: 87	ast birthday)	If Under 1 Year Months Days	If Unde Hours	r 24 Hrs. Min.	8. Date of Bir (Month, Da			9. Birthp Coun	olace (State or Foreign try)
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disp 1 Burial 2	☐ Cremation	3 Remov	al from State	20b. F	Place of Dispo	psition (Name of matory or other place en_Memoria Park	9)7	Dec.	19,		ocation - C		
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bu	Medical	(Check 2	Medical E	xaminer: On	the basis of	examination	n and/or inves	occurred at the time stigation, in my opinic s, death occurred at t	on, death o	occurred at	the time, date	and plac	e, and due to	o the car	use(s) and manner stated.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 42737 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 ^{Day} 2011 Physician/ 17 A^{M} John Woodrowe Martin 1:10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester 11937 Grays Corner Road Berlin 5. Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F 4/191Country) VA Months Days Hours Min Director 214-12-6046 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location with the Maryland must be notified at Director 1 Yes 2 No MD Worcester Berlin 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò Funeral 23a 21811 USA 11937 Grays Corner Road items death 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Examiner If Yes, specify Cuban, Mexican, Puerto Rican, etc. ō þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: "natural" Completed 3 Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry (Give kind of work dorie during most of working life. DO NOT use retired) of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Commercial Fisherman Fishing 10 Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 Mary Ella Peterson John Patrick Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau John David Martin/son Waterview Dr., Ocean City MD 21842 .0134 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) State Crema 12/19/2011 Millsboro DE 21. Signature of Funer Viervice Licenses 22. Name and Address of Facility 108 William Street 21811 Berlin. Burbage Funeral Home 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heary failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final Physician/ ement! disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant
Unknown Day Pregnant at time of death been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Division of Vital Records, 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? 1 Yes 2 No certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death. Funeral Director: After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural injury 5 Pending Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check within 2 To the I only one 3 29d. Date signed (Month, Day, Year) 12/19/1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

200

31. Date filed (Month, Day, Year)

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DEC 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] | | for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Shirley Morton Miller 2352_M December Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot Easton Hospita emoria 8. Date of Birth If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Months Hours Min Country) 213-12-0218 92 **Director** 1 🗆 M 2 🗶 F 3-6-1919 MD Usual Residence of Decedent 28a-f shov 10d. Inside City Limits iral", or items 23a or 28a-f shor Examiner must be notified at 10a. State 10c. City. Town or Location Director 1 X Yes 2 No MD Talbot Easton 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21601 700 Port Street #324 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc Black, White, etc. ğ 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 Yes nan "natural", Medical Exan If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 72 alth and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 1 Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Mary Margaret Laing injury or other traumatic Ivon Morton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau Oxford MD 21654 103 E. Division St. Robin M. Valliant (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Chesapeake Cremation
Center 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 12-13-2011 4 ☐ Donation 5 ☐ Other (Specify) Stevensville, MD 21. Sign fore f F 2. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 1 200 S. Harrison St Easton MD 21601 Part 1. Enter the disease, or complications that raused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cerebavallular aclibent Immediate Cause (Final Physician/ don disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death ed by the a 1 Yes 2/1 s been signed the should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No has director, page 2 death? certificate 1 Yes 2 No **Division of Vital** 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 I DOA this filled in by the funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 24 hours after death.

Funeral Director: After 1 Accident
Suicid injury Natural 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Easton MD 21601 598 Cynwood Drive Ste. 104 Jorge H. Abrego, MD 31. Date filed (Month egistrar's Signature State

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Registrar

			State of Maryland State of Maryland		artment <i>tificat</i> e			1ental Hy	giene Reg. No. 2 (42739	
	Physicia	n/	1. Decedent's Name (First, Middle, Last) Jerry Edward McCarthy					2. Date of De	Day	Year	3. Time of Death	
% -	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City To	own or Loc	cation of Death	Dec.	1		8:56 a ^M	
تعبري	Examini	er	Casey House			Rockv				4c. County of Death Montgomery		
3	Funeral	2	5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday)	If Under 1	Year If	Under 24 Hrs.	8. Date of Bir	rth	9. Birth	place (State or Foreign	
	Director		578-64-3627 1 ⋅ M 2 □ F 63	Yrs.	Months	Days	lours Min.	Nov. 2	8,1948	Mar	yland	
	nd show at	'n	Usual Residence of Decedent 10a. State 10b. County 10c. City, 1	Town or Lo	cation	1				1	0d. Inside City Limits	
	// Aaryla 8a-fs tified	rect	Md. Montgomery	Silv	ver Sp	ring					1 ☐ Yes 2 🛣 No	
	the Na or 2	Funeral Director	10e. Street and Number		10f. Zip C	ode			10g. Citizen of	What Cour	ntry?	
	h with	ner	12407 Denley Road			06-38		USA				
	r deat	y Fu	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. \	Was Deceder f Yes, specify	nt of Hispa / Cuban, N	nic Origin? (Spe lexican, Puerto	cify Yes or No- Rican, etc.)	14. Rad Bla	ce - Americ		
21215-0036	s after	d by	1 ☐ Never Married 2 🛣 Married 1 🛣 Yes 2 ☐ No 1969—3 ☐ Widowed 4 ☐ Divorced 1 🖼 Yes 2 ☐ No 1969— Year or Dates. 1971—	- '	1 🗌 Yes 2	No S	specify:		Specify	. Wh	ite	
2-0	hour natur dical	Completed		16a. Deced	dent's Usual (16b. Kind of E	Business/In	dustry	
21	hin 72 ne. than '	mo	Elementary/Secondary (0-12) College (1-4 or 5+)	life. D	O NOT use re	etired)	ng most of worki	ng	. 1.	C		
2	Hygiel	Be C	17. Father's Name (First, Middle, Last)	Eleci	tronic		Matharia Mara	Cinat Middle	Audio Maiden Surnam		ems	
Maryland	uld be file Mental I narked o	To	Jeremiah John McCarthy				Anna Ma	rie Ho	rstkamp			
, Mar	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			19b. Mailir 1240	ng Address (S 7 Den1	ey Ro	Number or Rura	Route Numberer Spr	ing, Md	State, Zip (• 209	06	
Baltimore,			1 Burial 2 X Cremation 3 Removal from State	netery, cren	osition (Name matory or oth itan C	er place)		Date L4 2011	20c. Location Alexa			
Balti	permit. Departm Imports any inju		21. Signature of Funeral Service Acenses M01315	22	2. Name and	Address of	f Facility De V	/ol Fun	eral Ho	ne	, DC 20007	
			23a. Part 1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line.								Approximate	
	Physician/		Immediate Cause (Final disease or condition Amyloidosis	5							Interval Between Onset and Death	
	Medical Examiner		resulting in death) Due to (or as a consequent									
ы	ZAGITIMIO	er	Sequentially list conditions, b. — Due to (or as a consequen							\rightarrow		
	3 32	Examiner	cause. Enter Underlying Cause (Disease or injury	ice oij.								
	in and ial	Exa	that initiated events resulting in death) Last C. Due to (or as a consequent	nce of):								
00	e be e iysicia ne bur	Jical	d									
68760	tificat ing ph e as th	Med	IF FEMALE;									
Box 6	ath certificate be executed attending physician and for use as the burial reasit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 23c. If yes, outcome of pregnance 1 Live Birth 2 Fetal deceded 4 Pregnant at time of deals.	death 3	Ectopic pre	egnancy c <i>ifv</i>)				ate of deliv onth	ery Day Y ear	
). B	the de by the achec	hysi	9 Unknown									
s, P.O.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death. Within £4 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transition.	by	Part II. Other significant conditions contributing to death but not result	ing in the u	inderlying ca	use given i	in Part I.				ne cause of death?	
Records,	v requ	Completed						24a. Was	an 24b.		psy findings available	
Sec.	he lav te has age 2	omb							ormed?	prior to co death? 1 \(\subseteq \text{Yes} \)	mpletion of cause of	
a	ian: T rtifica ctor, p	Be C	25. Was case referred to medical examiner?			26. Place	of Death (Check		Z LANO	i Li ies	2 🗆 100	
of Vital	hysic his ce al dire	유	1 ☐ Yes 2 X No Hospital: 1 ☐ Inpatient 2 ☐ EF			Other:	4 Nursing Ho	me 5 Resi	idence 6 X Oth	ner (Specif)	Hospice	
ا م	ling P. J. After t funera	ate:	27. Manner of Death 1 Natural 5 Pending 28a. Date of injury (Month, Day, Year)	8b. Time of injury		. Injury at work?		28d. Describe	how injury occur	red		
Sior	death death ctor: /	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	e farm str	M eet factory o		2 🗆 No	29f Looption (Street and Numb	or or Pum	I Pouto Number	
Division	al or A s after I Direct	Cer	4 Homicide determined building, etc. (Specify)	5, 10,111, 51,	001, 1001019, 1	511100		City or To		Jer or riura	THOUSE THAT IS CIT.	
	lospita Hours uneral	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowled (Check 2 Medical Examiner: On the basis of examination a									
	the thin 24 the F	Me	only one) 3 Certifying Nurse Practitioner: To the best of my		, death occurr	red at the ti	ime, date and pla		the cause(s) and	manner as	stated.	
	O) § \$ \$ \$ \$		29b. Signature and sitle of certifier	2410		icense nui			29d. Date signe Dec.			
	, ,		30. Name and address of person who completed cause of death (Item 2:	3a) (Type 1		. 1 4.	J201		Dec.	14, 2		
			Debrah Miller, CRNP, 1355 Pic	card	Dr., S	Suite	100, R	ockvill	Le, Md.	20850		
	Stat Registra		31. Date filed (Month, Day, Year) OFC 1 9 2011 32. Registrar's Signature	pa	New York							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 4:50 p M December 15, 2011 Marie Elena McCarthy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** Days Hours 214-48-5749 Director 1 M 2 X F 89 April 22, 1922 MA Usual Residence of Deced 23a or 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 Yes 2x XNo MD Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 5929 Anniston Road 20817 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian. Armed Force 1 Never Married 2 Married "natural", or ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: 3 Widowed 4 ☐ Divorced If Yes Give Year or Dates th and Mental Hygiene.
It is marked other than "natun traumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Charles Ruggiero Palma Cataldo 19a. Informant's Name/Relationship (Type, Print) -Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau once. Patricia Anne McCarthy 5929 Anniston Road, Bethesda, MD 20817 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemeterly 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD Signature of Euneral Service Licenses Prancis J. Collins Funeral Home Inc 500 University Blvd. W, Silver Spring, MD 2090: 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Failure Respiratory disease or condition Medical resulting in death) a consequence of **Examiner** Aspiration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 No Pregnant at time of death signed by the at d be detached for g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should . Were autopsy findings available prior to completion of cause of death? 24a, Was an 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 🗌 Yes ၉ 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 Yes 2 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 10 m. D D0065505 December 15,2011 30. Name and add/ess of person who completed cause of death (Item 23a) (Type, Print) medical Cer br Rockville, MD 20850 9901 Pintana MD State

Registrar

DHMH 17 Rev 06-2011

Registrar

Box 68760

4121 5

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

amend State of Maryland / Department of Health and Mental Hygiene 11-09479 Rolando Grande Martinez 42742 2011 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month 0506 hrs Medical Examiner Rolando Grande Martinez December 17, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Wheaton Montgomery E/B Veirs Mill Road at Centerhill Street If Under 1 Year | If Under 24Hrs. | 8. Date of Birth (MM/DD/YYYY) | 9. Birthplace (State or Months | Days | Hours | Min. | 1952 | Foreign | E.L. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Director 58 Country)Salvador 217-96-1523 1 X M 2 F Yrs June 12 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 X No Silver Spring Montgomery and 2 should be filed within 72 hours after death with the Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 20902 11930 Andrew Court El Salvador Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces White, etc. 1 Never Married 2 X Married 2X No Yes Yes, Give Yeer 1 X Yes 2 No specify: Salvadorean Specify: White 3 Widowed 4 Divorced 至 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) pleted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) of Health and Mental Hygiene.
If item 27 is marked other than ther traumatic event, the Medical Baltimore, MD 21215-0036 Housekeeper Country Club Com 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 8 Miguelangel Grande Maria del Rosario Martinez 19a. Informant's Name/Relationship (Type, Print) -W1fe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11930 Andrew Court, Silver Spring, MD 20902 Maria Socorro Amaya de Grande rtant: If item 2 Date Dec. 22, 20c Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 Burial 2 Cremation 3 Removal from State crematory or other place) Pages I Gate of Heaven Silver Spring, MD 2011 Donation 5 Other Specify 22. Name an Address of Facility 21. Signature of Funeral Service Licensee rancis J. Collins Funeral Home 00 University Blvd. .W, Silver Inc. Spring, MD 2090 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical UNPENDED **AMENDED** 23d. Date of delivery signed by the attending phys be detached for use as the b IF FEMALE 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part li. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown Completed has been s 24b. Were autopsy findings available 24a, Was an autopsy prior to completion of cause of death? performed 2 No certificate ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other₄ Nursing Home 5 Residence 6 Other: Scene this P 1 Yes 2 No 28a. Date of Injury (Month, Day,Year) Dec 17, 2011 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death Certification Pedestrian struck by auto 1 Natural 0455 hrs 1 Yes 2 ✔ No 5 Pending : Funeral Director: etely filled in by the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 Could not be Suicide or Town, State)
EB Veirs Mill Road at Centerhill Street, Wheaton, MD determined Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medica 2 Medical-Examiner: On the trasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the one)

OCME State

Registrar

29b. Signature and title of o

30 Name and address

31. Date filed (Month

Mary G. Ripple MD.

UE

Deputy Chilef Medical Examiner

ause of death (Item 23a)

and manner stated

erson who co

29c, License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

December 18, 2011

				Type or Print AMEND ITEM State of Mary				All Copie WS Mental Hy	s Are Legi	ble.	1071.
			State RegistAMEND#2perMD12/		Certi	ficate of	Death	I	Reg. No. 2	111	4214
	Physicia Media	cai	1. Decedent's Name (First, Middle, Las	Ulysses				2. Date of De Month	Pay 2	Year	3. Time of Death 6-35 A M
	Examir	ner	4a. Facility Name (if not institution, give	street and number)	1 / 61	ib. City, Town, o	CVAV (/	4c. County o		seorgas
	Funeral		5. Social Security Number 6. Se		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bir (Month, Da	th av Year)		ace (State or Foreign
	Director		577-76-2150 12 Usual Residence of Decedent	7	4 Yrs.			10/18/	1957		" MD
	-f shore	ctor	10a. State 10b. County		c. City, Town or Local	tion	11.			100	d. Inside City Limits
	he Mai or 28a e notifi	Director	MD Prince G	eorges	: 1000 (10f. Zip Code	Iton	I	10g. Citizen of W	/hat Countr	1 WYes 2 No
	s 23a	Funeral	5299 85th St	reet, #10	Di	20	784		Unit	ed S	tates
	filed within 72 hours after death with the Maryland al Hyglene. 4 other than "natural", or items 23a or 28a-f sho dent, the Medical Examiner must be notified at	y Fur	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever i	in U.S. 13. Wa	s Decedent of I es, specify Cub	Hispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race Black	- Americar k, White, etc	
215-0036	rs after ral", o Exam	ed by	3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates,	1 [Yes 2 🗷 No	Specify:		Specify:	Bla	ck
15-0	72 hou "natu edical	Completed	15. Decedent's Ed (Specify only highest gra		(Give kin	nt's Usual Occup d of work done	during most of wor	king	16b. Kind of Bus	siness Indu	stry
212	led within it Hygiene. other thar ent, the M		Elementary/Seconday (0-12)	College (1-4 or 5+)	1 1	VOT use retired, lina EV	ngineer		Engine	eerin	ng
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_	and 2 sho Health an tem 27 is		Melvin Makle, Jr	Son	4213	Plunn			or, City or Town, St.		_
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		0b. Place of Disposit	ion (Name of		Date	20c. Location - 0	City or Tow	n, State
ltim	permit. Page 1 Department of Important: If it any injury or c		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licens)		coin	on of English A	2 2011	Brent	- 1204	1
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	ъ <u>ф</u>	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cor	sequence of):	- /		12.	1,-00	2	
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68760	ertifical ding ph	/Med	IF FEMALE:	23c. If yes, outcome of pr	regnancy						
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ital	sician: The certificate irector, pag	Be	25. Was case referred to medical examiner?	Hospital:		26. P	lace of Death (Che	ck only one)			
of V	Phys er this eral dir	e: 10	1 ☐ Yes 2 X No '	1 Inpatient 28a Date of injury	2 ER/Outpatient 28b. Time of	3 DOA 28c. Inju	4 ∟ Nursing F		dence 6 Other		
on	ending sath. or: Afte he fun	ficat	1 Autural 5 Pending 2 A cident Investigation	(Month, Day, Yea	ar) injury	M 1 🗆	k? Yes 2 No				
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral	Certificate	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp		, factory, office		28f. Location (City or To	Street and Number wn, State)	r or Rural R	oute Number,
	ospital hours ineral d filled	Medical		ician: To the best of my k							
*	the Hi thin 24 the Fu	Mec	only one) /3 Certifying Nurs	ner: On the basis of examine Practioner: To the best		th occurred at the	ne time, date and pla		ne cause(s) and mar	nner as state	ed.
	43684		29b. Signature and title of certifier	1		29c. Licens	number 7	12	29d. Date signed	100 pth, Da	ly, Year)
	`		30. Name and address of person who c	ompleted cause of death	(Item 23a) (Type, Prin	it) /	2-/		10	17/	1-700
	- 0-		31. Date filed (Month, Day, Year)	VEUIS, MD 32. Registrar's S	300	40>11	THE DK	IVE. C	HELECU	1, M	D 20783
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month DEC Physician/ 2011 9:16 A M MONTGOMERY JOHN Α. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S CHEVERLY PRINCE GEORGE'S GENERAL HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day AUG • 26 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Country Months Hours Director 232-64-4159 Usual Residence of Decedent show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10c. City, Town or Location Director 1 X Yes 2 ☐ No HYATTSVILLE PRINCE GEORGE'S 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 5227 KENILWORTH AVE. #102 20781 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 X Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes Give Year or Dates.VIETNAM WHITE Completed 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) FEDERAL GOV'T. 12 CONSTRUCTION WORKER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ **HENDERSON** MARY RUSSELL URIS MONTGOMERY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5227 KENILWORTH AVE. #102, HYATTSVILLE, MD. 20781 JAMES MONTGOMERY/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 12-15-2011 RIVERDALE, MD. CHAMBERS CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee ress of Facility FUNERAL HOME & CREMATORIUM, P.A. VELAND AVE., RIVERDALE, MD. 20737 M00091 CLEVELAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Phytician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury and To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medica Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Pregnant at time of death 1 Yes 2 9 Unknown 2 🗌 No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has ral director, page 2 performed 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 2 XN0 ျပ 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: within 24 hours after death.

To the Funeral Director: After of the funeral filled in by the fun Natural 5 Pending work' 1 🗌 Yes 2 🗌 No 🔲 Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 E only one) 29d. Date signed (Month, Day, Year) 29b. Signature and Mile of certifie D63688 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 10, 2011 Patricia Joan Murphy 2:30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Clifton Woods Silver Spring Montgomery 6. Sex 7. Age (In vrs. last birthday) If Under 8. Date of Birth If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 579-40-9464 Hours Min. **Director** 1 M 2 X F 81 Washington, DC May 23, 1930 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a, State 10c. City, Town or Location 10b. Count Director 10d. Inside City Limits MD 1 Yes 2 No Montgomery Chevy Chase 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a -Examiner must be 7404 Meadow Lane 20815 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify: SpecifyWh1te "natural", 3 X Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 hand Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 4 Homemaker Own_ Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edward Joseph Michael Lucene Rose Fuller 1 and 2 should by Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael P. Murphy/Son 11310 Attingham Lane, Glenn Dale, MD 20769 injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Dec. Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2011 Silver Spring, MD 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Non-Hodgkins Lymphoma disease or condition <u>5yrs</u> Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate a and To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician buri Physician/Medical P.O. Box 68760 the as nding r yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE nse 23b. Was decedent pregnant 23d. Date of delivery jo in the past 12 months?
1 ☐ Yes 2 🄀 No
9 ☐ Unknown Month Year Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed d be de þ Alzheimer's Dementia Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy performed? Yes 2X N 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 4 Nursing Home 5 Residence 6X Other (Specifiv) 2 🛣 No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of within 24 hours after death.

To the Funeral Director; After to appletely filled in by the funeral 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

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31. Date filed (Month, Day, Year) 1 5 201

Linda M. Burrell, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2730 University Blvd, Wheaton, MD 20902 32. Pegistrar's Signature

11 mg

D35996

29d. Date signed (Month, Day, Year)

Dec. 12, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Bernard William McQuade 6:20 December 14. 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8505 Springvale Road, #224 Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours **Director** 218-38-6071 1 🔀 M 2 🗆 F 71 Usual Residence of Deceden Jan. 30, 1940 show or 28a-f shov notified at death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Silver Spring MD Montgomery ō 10e. Street and Number 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 8505 Springvale Road, #224 20910 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14, Race - American Indian, Armed Forces Black, White, etc. þ 1 XNever Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 within 72 hours after Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e 1 and 2 should be filed within 72 is of Health and Mental Hygiene. If item 27 is marked other than "reprorement traumatic event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) Computer Programmer Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bernard William McQuade Anne Marie McGarry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carmel A. Lee/Executor of Will 4 Ashmont Court, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 5 Department of Important: If it any injury or o 1X Burial 2 Cremation 3 Removal from State Dec. 21, 4 ☐ Donation 5 ☐ Other (Specify) Olivet Cemetery Washington, DC Signature of Funeral Service Licen Francis J. Collins Funeral Home Inc. d1 66 500 University Blvd. W., Silver Spring, MD 23a. Part 1: Inter toe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Liver Cirrhosis disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Alcohol Abuse Sequentially list conditions, ne if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last the burial attending physician Physician/Medical Box 68760 as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Pregnant at time of death Unknown the 9 Unknown Division of Vital Records, P.O. been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Hypertension, Cerbrovascular Disease, Chronic Kidey 1 ☐ Yes 2 😾 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an Disease has autopsy performed? Yes 2 No death? After this certificate 1 🗌 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2X No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 🗆 Yes 2 🗆 No Natural Accident 5 Pending injury after death. the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 [only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and 29d. Date signed (Month, Day, Year) MD 4 D61007 December 15, 2011

Registrar

State

30. Name and address of

31. Date filed (Month, Day, Year

Kenneth Khandagle, MD

DEC 2 0 2011

12520 Prosperity Drive, #320, Silver Spring, MD 20904

person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend 4b, 10c&f per FH G923 1,9/12 dk
State of Maryland / Department of Health and Mental Hygiene 2011 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 12 Physician 1:00 AM 30 2011 Mary Margaret Minnick /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cumberland **Allegany** 17613 McMullen Hwy Rawlings | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 10 O1) Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 X F Months Maryland Director 76 220-30-8774 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Exemples in ust be notified at 1 □Yes 2 No Director MD Allegany Cumber Land Rawlings 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21502 21557 U.S.A. 17613 McMullen Hwv Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼ No 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2No If Yes, Give Year or Dates: Specify: <u>会</u> Specify. 3 Widowed 4 □ Divorced White "natural", Completed of Health and Mental Hygiene, Item 27 is marked other than "natur other traumatic event, the Medical. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nellie Lavin Lancaster Robert Hillary Lancaster မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 147 Pinto MD 21556 sister Erma Wymer 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit, Pages 1
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Cumberland Crematory 12-31-2011 Cumberland, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Sowers Funeral Home, P.A. MO0547 14160 Frostburg. MD 21532 DOWLES 60 W. Main St., Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician (areinom disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the carry of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Ab+#VbDivision of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 Ne 3 🗆 Ectopic pregnancy Month 5 Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by ves 2 No 3 Probably 4 Unknown should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t irector, page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1: Natural 2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the ft. 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the date and place and place are the time, date and place and place, and due to the cause(s) are the time, date and place, and due to the cause(s) are the time, date and place and place are the time, date are the time, date are the tim Medical 29a. Certifier (Check only one) and manner-stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) leţed cause di death (Item 23a) (Type, Print) 30. Name and address of person who comp Setan De Cambeland MI) State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 42748 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 134 Paula Elise McNinch-Blonsky December 2011 Medical 4a. Facility Name (if not institution, give street and number. 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot Easton Memorial Hospital 7. Age (In vrs. last birthdav) If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 24 Hrs. **Funeral** Hours 555-74-7363 Director 1 🗆 M 2**X** 🗆 F Alabama 05/04/1948 63 r 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Maryland Talbot Easton 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code o 10g. Citizen of What Country? or items 23a or miner must be r Funeral USA 21601 7415 Casey Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates. should be filed within 72 hours after 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: "natural". 3 Widowed 4 Divorced Completed White Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the Women's health Nurse Practitioner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ Cherry Burton Lee Knight Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7415 Casey Ave., Easton, Maryland 21601 19a. Informant's Name/Relationship (Type, Print) Howard M. Blonsky/spouse permit. Page 1 and 2 sh
Department of Health a
Important: If item 27 is
any injury or other trai 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 12/20/2011 Dover, Delaware Capitol Crematory 4 Donation 5 Other (Specify) Moore Funeral Home, P.A. 22. Name and Address of Facility ure of Funeral Service Lige Denton, Maryland 21629 12 South Second Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ 051 disease or condition SE Medical resulting in death) onseque ce of Due to (or as a Examiner Sequentially list conditions Examiner Due to (or as a cor ence of if any, leading to immediate the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. Cause (Disease or injury and burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death g 🗌 Unknown g Anknown been signed by significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed death? After this certificate 20 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 🗵 Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No 1 Yes Certificate: To 1 Impatient 2 ER/Outpatient 3 DOA funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 🗌 No s after death Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a

To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature a of title of certifie 29d. Date signed (Month, Day, Year) XX62626 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 8:35 P 2011 Sandra J. Nissman December 14, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Atrium Kosher Potomac Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Months 1 M 2 KF Yrs. July 2. 1941 Washington. DC 70 Director <u> 218-38-6765</u> Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 X No Directo Maryland Montgomery Gaithersburg 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7701 Mineral Springs Drive 20877 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 1 Tyes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 🛣 No Caucasian Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louis Fine Rose Paragoff ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7701 Mineral Springs Drive, Gaithersburg, MD 20877

Date | 20c. Location - City or Town, State Department of Health Important: If item 27 any Injury or other trong once. <u> Joseph J. Nissman, Spouse</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park 12/19/2011 Rockville, Maryland 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service Licensee MO1102 Ra 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Arrhythmias /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death

9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🕅 No 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed Be Certification: To

To the Hospital or Attending Physician: The law requires that the death certificate be executed burial Division of Vital Records, P.O. Box 68760, attending physician for use as the buria this certificate has but director, page 2 sh After within 24 hours after death

To the Funeral Director:
completely filled in by the

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

28a-f show

ns 23a or 28a-f sh must be notified

"natural", or items

th and Mental Hygiene.
7 is marked other than "natul traumatic event, the Medical

t of Health a

			24a. Was an autopsy performed? 1 □ Yes 2 ▼ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No							
5. Was case referred to medical	26. Place of Death (Check only one)										
examiner? 1 Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 \(\text{Nursing Home} \)	5 ☐ Residence 6	Other (Specify) Assisted							
7. Manner of Death 1	(Month, Day, Year) Injury	. Injury at Work? 28d. 1 ☐ Yes 2 ☐ No	. Describe how injury	y occurred Living							
3 Suicide 6 Could not be determined		ifice 28f.	Location (Street and City or Town, State)	d Number or Rural Route Number,)							
29a. Certifier 1 Certifying P	hysician: To the best of my knowledge, death occurred at miner: On the basis of examination and/or investigation, in	the time, date and place, and my opinion, death occurred	due to the cause(s) at the time, date and) and manner as stated. I place, and due to the cause(s)							

1 0 2011

29b. Signature and title of certifier

DEC

29c. License number

29d. Date signed (Month, Day, Year) December 15,2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

344 University Blvd West #113, Silver Spring, Maryland 20901 Wilkinson Ninala, 31. Date filed (Month, Day, Year)

State Registrar

Medical

11-09372 Alfred Nelka Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar	Certi	ificate of l	Death		Re	g. No.	
Physician/ Medical Examiner	 Decedent's Name (First, Middle, I 	Last) Jelka				2. Date of Deat Month December	Day Year	3. Time of Death 0620 hrs
	4a. Facility Name (if not institution, 1143 Dicus Mill Road	give street and number)		. City, Town, or L Millersville	ocation of Deat	1	4c. County of [Anne Arur	
Funeral Director	215-24-1709	7. Age (In yrs. las 84	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24Hrs Hours Mir			B. Birthplace (State or or oreign Maryland Country)
nd how any cc.	Usual Residence of Decedent 10a. State 10b. County MD Anne A	arundel 10c. City, T	own or Location	ville				10d Inside City Limits 1 Yes 2 XNo
the Maryland a or 28a-f show tiffed at once. Director	10e. Street and Number 1143 Dicus Mil	l Road		10f. Zip Code 2110	8	10	og. Citizen of What USA	Country?
0036 within 72 hours after death with the Maryland giene. her than "natural", or items 23a or 28a-f sho Medical Examiner must be notified at once. ompleted by Funeral Director	11. Marital Status 1 Never Married 2 Marri 3 X Widowed 4 Divorc 15. Decedent's Education (Specify Elementary/Secondary (0-12)	1 X Yes 2 No or Dates: 2 No	If Yes 17 1 Y 16a. Decedent's during mos	e, specify Cuban, Yes 2 No Usual Occupation It of working life.	Mexican, Puerto specify: on (Give kind of DO NOT use ret	work done	14. Race - A White, e Specify: 16b. Kind of Busin Plastic	White ess/Industry
7 2 2 4	5 17. Father's Name (First, Middle, La		Machir		8.Mother's Name	e (First, Middle, M na Brova	faiden Surname)	Pidiic
AD 21215- 2 should be filed h and Mental Hyg Tri is marked out matic event, the	Frank Nelka 19a. Informant's Name/Relationship Madelyn McElwee		19b. Mailing A	Address (Street	and Number or	Rural Route Num	ber, City or Town, Sville, M	State, Zip Code)
Baltimore, MD 21215 permit. Pages I and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked or injury or other traumatic event, th	20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other Spec	3 Removal from State 20b. Pla	L ace of Disposition ematory or other	on (Name of cem	etery, Dec	Date 19, 2011	20c. Location - Ci Baltimor	ty or Town, State
Balti permit. Departu Import injury	21 Signature of Fureral Service Life	1. Jansoni	/ 495	me and Address MATION I Ritchie	e Hwy,		a Park, M	D 21146
Physician Medical Examiner	23a. Part I. Enter the disease, or co failure. List only one cause on Immediate Cause (Final disease		4	mode of dying, s	such as cardiac	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
	or entition resulting in death) Sequentially list conditions,	Due to (or as a consequence of): b						
ed nsit Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):						
execut an and al - tra	UNPENDED	dAMENDED						
Division of Vital Records, P.O. Box 68760, To the Bospital or Atteodiog Physician: The law requires that the death certificate be exect within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician an completely filled in by the funeral director, page 2 should be detached for use as the burial - triedical Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkno	23c. If yes, outcome of pregnate 1 Live birth 4 Pregnant at time of deat	2 Fetal	death 3 [Ectopic pregn	ancy	23d. Date of de Month	livery Day Year
P.O. E res that the signed by the detached by the detached d by Ph	Part II. Other significant condition	ns contributing to death but not res	ulting in the und	derlying cause gi	ven in Part I.			te to the cause of death? Probably 4 Unknown
Division of Vital Records, rat or Atteodieg Physician: The law require is after death. a) Director: After this certificate has been sixed in by the fineral director, page 2 should be striffication: To Be Completed						24a. Was a autops perfor	sy prio med? dea	re autopsy findings available r to completion of cause of th? Yes 2 No
ician ician s certi rector	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2 E	R/Outpatient		of Death (Check		Residence 6 🗸	Other: Scane
n of Vi idiog Phys h. After this funeral di	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury 2	28b. Time of Inju	ary 28c. Injury	vat Work?		low injury occurred	54101.00010
Division of pital or Atteodiog ours after death. eral Director: Aft filled in by the func	2 Accident Investig 3 ✓ Suicide 6 Could n 4 Homicide	Dec 13, 2011 (28e. Place of Injury - At home				or Town, St		or Rural Route Number, City
To the Hospi within 24 hou To the Funer completely fil	29a. Certifier 1 Certifying Phys	sician: To the best of my knowledge ner:On the basis of examination and and manner stated.	e, death occurre			due to the cause	e(s) and manner as	stated.
>	29b. Signature and title of certifier	· Pon L		29c. License O.C.N			29d. Date signed December 14	(Month, Day, Year) I, 2011
Agx'	30. Name and address of person when Patricia Aronica-Pollak I	no completed cause of death (Item 2 MD. Assistant Medical E)		00 W. Baltim	ore Street, E	Baltimore, MI	21223	
State Registrar		32. Registrar's Signature	1. Sa	Ked				

DHMH 17 Rev 06-2011

State of Maryland / Department of Health and Mental Hygiene 2 U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Virginia Mae Nettles Physician/ 9:05a_M 2011 Dec. 15, Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Manor Care of Potomac Potomac Montgomery 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 246-46-2489 1 🗆 M 2 🕱 F Year, Hours Director North Carolina 20, 1930 Sept. Usual Residence of Decedent 28a-f show 10a. State 10b. Count "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City. Town or Location Director 10d. Inside City Limits MD Montgomery Rockville 1 XYes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral Monroe Street apt#201 20850 United States 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married þ Yes 2 X No 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Black Specify: 3 Divorced 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other that any injury or other traumatic event, the N College (1-4 or 5+) Marriott 9th Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk. ည Boyd Nettles , Zip Code) **n** 20850 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Jesse Roberts Nettles/ son Rockville, MD 8 Monroe Street, apt#201, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Beltsville, Maryland 12/19/2011 Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McGuire Funeral Service, Inc. Signature of uneral Service Licenses 20012 7400 Georgia Avenue, NW, Washington DC Ungre 20 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic non-small cell Lung Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury Due to (or as a consequence of) y physician and that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending pt IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 Yes 2 X No Day Pregnant at time of death Month Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown detached 9 Unknown is been signed by it should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chronic Kidney Disease Hospital or Attending Physician: The law requires Completed 1 🔀 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy page performed? death? ☐ Yes 2 🔀 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Tyes 2 🗶 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) nours after death.

neral Director: After the filled in by the funera 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work?
1 Yes 2 No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral D 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 🗋 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier the hin the 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year)

State Registrar

Thomas Masterson, 6858 Old Domimion Drive, apt#104, McLean, VA 22101 MD ; 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

romas

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

D50534

Dec. 16, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0965 AM December ZOI Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Baltmore Mary lan 3 If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month. Day. Director M 2 🗆 F EWYORK ital Hygiene.

od other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No ANNE ARI 10e. Street and Number 10g. Citizen of What Country? Funeral 1.5.A MARCO 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Specify: WhITE 3 Divorced Completed Year or Dates. 1966 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 2.5 GOVERNMENT pennit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other I any injury or other trainman. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 DORIS P. WEIDMAN NILS K.B. NILSEN 19a. Informant's Name/Relationship (Type, Print) BERNCE NILSEN 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ODENTON, MD. JAKERTY FUNERAL HOME 2601MOUNTAIN RD. sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ure. List only one cause on each line. Part 1. Enter the disshock, or heart failure Interval Between Immediate Cause (Final Onset and Death Physician/ morrhag ntracrania disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-t attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Vear Pregnant at time of death Unknown the 9 Unknown P.O. signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 s autopsy perforn death? within 24 hours after death.

To the Funeral Director: After this certificate I 2 X No Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tyes 2 XNo Other: 1 Minpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 \(\sime\) Yes injury 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier MID December AU4176435Cl01517 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

And rew

31. Date filed (Month, Day, Year)

Registrar's Signature

MD

timore

21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 13, 2011 Month Tuong D. Nguyen 0620 December 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Months Days Hours 586-14-8690 1 🗆 M 2 🗓 F 90 02/15/1921 Vietnam Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 🗌 Yes 2 🗓 No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2120 Queensguard Road 20906 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🗶 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify 3 Y Widowed 4 Divorced Asian Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hao Van Duong Yen T. Nguyen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15115 Interlachen Dr. #206, Silver Spring, MD 20906 Daniel Nguyen - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Donation 5 Other (Specify) Gate of Heaven Cem. 12/16/2011 Silver Spring, MD 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee MD1564 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Sepsis resulting in death) Due to (or as a consequence of): Pneumonia Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Respiratory Failure Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician/ Medical **Examiner** Examin

Physician/

Medical

Examiner

Funeral

Director

28a-f show

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permit. Page 1 a
Department of I
Important: If ite
any injury or ot

traumatic event, the Medical

within 72 hours after

Baltimore, Maryland 21215-0036

Examiner must be notified at

Director

Funeral

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Completed

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and Hospital or Attending Physician: The law requires that the death certificate be executed attending physician I for use as the buris detached ģ page 5 has this within 24 hours after death

To the Funeral Director: A
completely filled in by the f

Division of Vital Records, P.O. Box 68760

Physician/Medical

þ

Completed

Be မ

Certificate:

Medical

Dementia					1 □ Yes 2 🛭	No 3 ☐ Probably 4 ☐ Unknown
H/O Stroke					24a. Was an autopsy performed? 1 ☐ Yes 2 🛣 No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical			26. Place of Death (Che	eck on	ly one)	
examiner? 1 Yes 2 X No	Hospital: 1 ☑ Inpatient 2 □	ER/Outpatient 3	DOA Other: 4 Nursing	Home	5 Residence 6	Other (Specify)
27. Manner of Death 1 ↑ Natural 5 Pending 2 Accident Investigatio		28b. Time of injury	28c. Injury at work? 1 Yes 2 No	28d	. Describe how injury	occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	1 28e Place of Injune. At he		28f	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
(Check 2 Medical Exam	rsician: To the best of my know liner: On the basis of examinationse Practitioner: To the best of its	on and/or investigation, i	in my opinion, death occurred	at the	time, date and place,	and due to the cause(s) and manner stated.

D60826

29d. Date signed (Month, Day, Year)

December 13, 2011

State Registrar

31. Date filed (Month, Day, Year) 1 5 2011

30. Name and address of person who completed

29b. Signature and title of certifier

Kshama Garg.

1500 Forest Glen Road, Silver Spring, Maryland 20910

cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 11 2011 Physician/ James Nick 0250 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Aug 5 1923 1**X** M 2 □ F Months Days Hours Maryland 218-12-9407 88 Director Usual Residence of Decedent show 10a State 10b. County 10c, City, Town or Location 10d. Inside City Limits at Director Examiner must be notified 28a-f 1 ☐ Yes 2X No Maryland Anne Arundel Shady Side 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? items 23a Funeral 20764 1421 Shady Rest Rd. USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. "natural", or þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: Black 3X Widowed 4 ☐ Divorced Completed permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5th Ō Bricklayer N. Litterio Co. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John T. Nick Marion Holland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carmelia A. Hicks(Daughter) 1011 Red Mapleview Terrace Churchton, Md. Baltimore, 20a Method of Disposition 20c. Location - City or Town, State 20th 4Place of Pisposition (Name of cemetery, Crematory or other place) 1 X Burial 2 Cremation 3 Removal from State U.M. Church 12-19-11 Shady Side, Md. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses Wmame Redese of BellitSons Mortuary, P.A. 1922 Forest Dr. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ intracranial disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially let conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine and that initiated events resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Box 68760 the use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month 5 Other (specify) Pregnant at time of death signed by the a Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 has within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No To the Hospital or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and manner stated Control of the cause of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Control of the cause of th completed (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 661 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parkway 2001 Medica

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Annapohs, ma

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Anna Elizabeth PENN 10:00 PM December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Meritus Medical Center Hagerstown Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday, **Funeral** Months Hours (Month, I 1 M 2 X 93 217-10-3394 Director ~1918 Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 X Yes 2 ☐ No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 23a Funeral 21740 USA 907 Summit Avenue or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 9 Maryland 21215-0036 72 hours after 1 ☐ Yes 2X No Specify. white Specify: "natural", 3 X Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d 2 should be filed within 72 lath and Mental Hygiene. 127 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) hospital 0 cashier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 unknown Simon Edward Snyder Sr. other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar. Important: If item 27 is any injury or are 10025 Beaver Creek Church Rd., Hagerstown, Md. 21740 Jack Edward Penn - son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/29/11 Hagerstown, Maryland Cedar Lawn Mem. Park Funeral Service Lice 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause are each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) numous Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or imjury ing physician and as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No ō Month Year Pregnant at time of death 1 ☐ Yes ∠ us be detached Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by Hypernatremia 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of Dehytration 24a, Was an autopsy has death? certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, to 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 1 No 욘 1 Dinpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending М Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 50362 W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) incent 13424 Pennsylvania antone 31. Date filed (Month, Day, Ye State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 5:40 am Johnny Pachikara December 17.2011 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In vrs. last birthday **Funeral** Months Hours Director 163-64-5291 1 X M 2 🗆 F Yrs 60 01/10/1951 India Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location at Director Examiner must be notified 1 Yes 2 X No Derwood Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe ö Funeral "natural", or items 23a 20855 India 15825 Anamosa Drive 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🕱 No Black, White, etc 1 Never Married 2 X Married þ Pachikara 5 Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify Specify: Asian Indian 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) Mass Transit Power Supervisor injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname, 17 Father's Name (First Middle Last) and Mental F is marked of P Annamma Vadakedam Abraham Stephen Pachikara 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau 15825 Anamosa Drive. Derwood. Maruland 20855 Mary Pachikara - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 12/21/2011 | Germantown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Souls Cemetery of F rall Service Licen 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. et and Death JOYLAYS Immediate Cause (Final OF PROSTATIC CANCER 5 TAGE Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, loading to in necial cause. Enter Underlying Cause (Disease or injury that initiated events specific indeed by Last Due to (or as a nonsequence of) and Hangt Exam that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death 1 Yes 2 L 9 Unknown the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy has Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28c. Injury at work? 1 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: within 24 hours after deam.

To the Funeral Director: After 1 X Natural 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 68315 Vec. 18, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Center Drive, Rockville, Md. 20850 Medical Chi MD 31. Date filed (Month, Day, Year, State **DEC 2 0 2011** Registrar

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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Sang Shin Park December Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Rockville Casey House - Montgomery Hospice If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Social Security Number Age (In yrs. last birthday) **Funeral** Min (Month, Day, Year) 326-38-1457 Director 1 **X** M 2 □ F 78 Oct. 25,1933 "natural", or items 23a or 28a-f show dical Examiner must be notified at 10c. City, Town or Location Director Bethesda MD Montgomery 10e. Street and Number 10f. Zip Code Funeral 20817 10012 Clue Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? ò 1 Never Married 2 X Married 1 Yes If Yes, Giv 2 X No 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 3 Widowed 4 Divorced Completed Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Microbiologist Department of Health and Mental Hygier Important: If item 27 is marked any injury or con-Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Young Tae Park Gan Nan Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ho Cha Park (Spouse) 10012 Clue Drive, Bethesda , MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State December 4 Donation 5 Other (Specify) Souls Cemetery 22, 2011 22. Name and Address of Facility DeVol Funeral Home, 10 East Deer Park Drive, M000689 Gaithersburg, MD 20877 Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock the preart failure. List only one cause on each line. mmediate Cause (Final Physician/ Cerebrovascular Disease disease or condition Medical resulting in death) **Examiner** Atrial Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) and requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 24a. Was an autopsy 2 X No Be 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) examiner?
1 \(\sum \) Yes 2\(\bar{X} \) No Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 🗌 Yes 2 🗌 No 1 X Natural 5 Pending Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State) 29a. Certifier 1 ីX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)
December 18, 2011 29c. License number D0060634 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bindu Joseph, M.D., 1160 Varnumb Street NE, Washington DC 20017-2106

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 17 2011 6:50 4c. County of Death Montgomery Birthplace (State or Foreign Country) Korea 10d. Inside City Limits 1 Yes 2 X No 10g. Citizen of What Country? <u>United States</u> 14. Race - American Indian, Black, White, etc. Specify: Asian 16b. Kind of Business/Industry Cancer Research 20817 20c. Location - City or Town, State Germantown, MD Approximate Interval Between Onset and Death 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 🗌 No 1 🗌 Yes Hospice 28f. Location (Street and Number or Rural Route Number,

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Year) **DEC 2 0 2011**

Registrar's Signal

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗍 42759 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2011 Vincent Α Pepper 11:18 a M Dec. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rockville Nursing Home Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Birtripic Country) PA Days Min. 1 33 M 2 □ F Months Hours (Month, Pay, Year) 1927 84 **Director** 538-22-0185 May Usual Residence of Decedent or 28a-f show tal Hygiene. ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Rockville MD Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20850 USA 37 Maryland Avenue, #539 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🖾 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 White 1 ☐ Yes 2 ☐ No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Media Attorney/Broker Communications Law Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of 2 Labina Sanderson Albert E. Pepper permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37 Maryland Avenue, #539, Rockville, MD 20850 Donna A. Pepper/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 █ Other (Specify)entombment 22, Dec. Gate of Heaven Cemetety Silver Spring, MD 2011 Signature of Funeral Service License Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part I. Entertite disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Dementio obe Physician/ disease or condition Medical resulting in death) Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): anding physician and use as the burial To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 9 Unknown signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the lirector, page 2 s autopsy performed' 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ျှ 1 Tes 2 No Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 DOA this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral 1 Natural 5 Pending 1 Tyes 2 🗌 No 2 Accident
3 Sulcide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 **Dedical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00054566 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunitha Bhogaville ,9501 Georgia Anny #1-17, Silversing 31. Date filed (Month, Day, Year) State DEC 2 0 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 10:40 P M MARIE GIBLIN PIERCE DECEMBER 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Friends Nursing Home Sandy Spring 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours **Director** 288-22-5092 Usual Residence of Deced 1 🗆 M 2 🗷 F May 17, 1928 Ohio 83 Yrs 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location at 10a, State with the Maryland Director must be notified 1 Yes 2 X No Maryland Montgomery Kensington 10f. Zip Code 10g. Citizen of What Country? 5 10e. Street and Number 20895 items 23a Funeral 9600 Hillridge Drive United States death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ō by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 nours after 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White "natural" 3 🛮 Widowed 4 🗆 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Ith and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med College (1-4 or 5+) Elementary/Secondary (0-12) Medical Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Conlin Mary Ρ. John Foley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 9600 Hillridge Drive, Kensington, MD 20895 Linda Hill / Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State 12/15/11 Alexandria, Virginia Metropolitan Crem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Strvia Line see 22. Name and Address of Facility Muriel H. Barber Funeral Home 20882 P.O. Box 5038, Laytonsville, MD 01 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Provident Pneumonia days disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day ò Pregnant at time of death the 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Hypertension 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 M Nursing Home 5 A Residence 6 A Other (Specify) 2 🗹 No 1 Yes မ 1 🗌 Inpatient 2 🗎 ER/Outpatient 3 🗌 DOA this funeral 28a. Date of injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🗹 Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the f Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated dititle of certifie 29c. License number 29d. Date signed (Month, Day, Year, 29b. Signature a December 14, 2011 D 18726 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5

DHMH 17 Rev 06-2011

State

Registrar

Arthur Schoengold, M.D.

5

31. Date filed (Month, Day, Year)

Registrar's Signature

18111 Prince Philip Dr., T-10, Olney, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ GERALD JOSEPH ROEMER Dec. 201 1:52 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Senator Bob Hooper House Forest Hill If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number . Age (In yrs. last birthday) **Funeral** 219-42-7236 Director 1 **X** M 2 □ F 65 15/1946 Maryland Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No MD. Jarrettsville Harford 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Funeral 3875 Old Federal Hill Road 21084 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian "natural", or iter Armed Forces? 1 Never Married 2 X Married þ If Yes, Give Year or Dates. Vietnam 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 3altimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4 or 5+) Shop Manager Automotive Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ပ Steppe Woodard Dean Geraldine Μ. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2108419a. Informant's Name/Relationship (Type, Print) Important: If item 27 is any injury or other trau Old Federal Hill Rd. (Wife) 3875 Jarrettsville, MD Phyllis M. Roemer 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Dec. 30. cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Jarrettsville 2011 Jarrettsville, MD Cem. 22. Name and Address of Facility $\mathbf{E}_{ullet} \mathbf{G}_{ullet}$ Kurtz & Son Funeral Home, Jarrettsville, Maryland P.A. 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate erval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Fetopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year 5 Other (specify) Pregnant at time of death should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perform To the Hospital or Attending Physician: The law 1 Yes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Hospital 4 Nursing Home 5 Residence 6 Other 2 X No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA in 24 hours after uccome.

In Funeral Director: After the bletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral filled in the funeral fill 28d. Describe how injury occurred 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural 2 Accident iniury 5 Pending work? 2 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check within 24 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title 9+1 30. Name and add e of death (Item 23<u>a)</u> (Type, Print State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sara Jean Raines 9:20 ΑM December 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Tate Hospice House Linthicum If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Months Days Hours Month 579-12-1978 90 **Director** Washington, DC December 1921 Usual Residence of Decedent show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits 28a-f Maryland Prince George's Hyattsville 1 X Yes 2 No Ö 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? or than "natural", or items 23a of the Medical Examiner must be with. Funeral 3921 Longfellow 20781 Street USA filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 ☒ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Banking Secretary traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ရ Aubrey Hayden Mary E. Heimer Department of Health an Important: If item 27 is n any injury or other traumonce. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diana L. Morris / Daughter 4700 Water Park Drive, #E, Belcamp, MD 21017 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State George Washington Cemetery 12/28/2011 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Cerebrovascular Accident disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Hypertensive Heart Disease Sequentially list conditions cause. (Disease or linjury Directo (or as a nonsequence of, as the burial-transit Hyperlipidemia and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical requires that the death certificate be Box 68760 attending IF FEMALE: nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) for in the past 12 months?
1 ☐ Yes 2 ☒ No Pregnant at time of death Month Day Year detached the Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be Division of Vital Records, 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe certificate Yes 2 No 2 🗌 No 1 🗌 Yes Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 🔀 No Other: ၉ Hospice 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗵 Other (Specify) Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No death. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after of Funeral Direct determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29c. License number 29d. Date signed (Month, Day, Year) tau Tue D46998 12/22/2011

State Registrar TU MD

3415 HAMILTON ST HYATTSVILL MD 20782

42763

		•	For State Registrar		Cert	ificate of D	eath	Re	eg. No.				
	Physicia	n/	1. Decedent's Name (First, Middle, Last) James Russell Ri					2. Date of Death Month Decembe		3. Time of Death 12:09 AM			
	Medic Examin		4a. Facility Name (if not institution, give si			4b. City, Town, or	Location of Death	Decembe	4c. County of Death	12.05 11			
1	}		Washington Adven		5 1 4 5 a 5 a 5	Takoma	Park If Under 24 Hrs.		Montgomer				
	Funeral Director		5. Social Security Number 217-16-8903 Usual Residence of Decedent	7. Age (In yrs. last to 93	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, March 20	Year) 9. Birthp Count 1918 Wash	lace (State or Foreign try) ington, DC			
	and show fat	Į.	10a. State 10b. County	10c. City, To					1	0d. Inside City Limits			
	Maryl 28a-f otifiec	irect	Maryland Prince G	eorge's Mour	nt Ra	inier				1 🖾 Yes 2 🗌 No			
	s 23a or	Funeral Director	10e. Street and Number 4210 32nd Street			10f. Zip Code 207	12	1	0g. Citizen of What Coun USA	try?			
9003	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ፟	۱ ا	as Decedent of His Yes, specify Cubar Yes 2 No	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e Specify: Whi	etc.			
21215-0036	/ithin 72 hor iene. r than "nat the Merica	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Seconday (0-12)		(Give ki life. DO	ent's Usual Occupa ind of work done d NOT use retired) tmaster	ation uring most of work	ing	16b. Kind of Business Inc US Postal S				
Maryland 2	s should be filed within 72 h and Mental Hygiene. 7 is marked other than "r rraumatic event, the Med	To Be	17. Father's Name (First, Middle, Last) J. Russell Rice				18. Mother's Name	e (First, Middle, M e Lanthr					
	and 2 shouk Health and N tem 27 is me		19a. Informant's Name/Relationship (Type Allen W. Rice /						city or Town, State, Zip C				
Baltimore,	Page nent o ant: If ıry or		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)										
Balt	permit. Page Department Important: I any Injury o		21. Signature of Funeral Service Licenses	e Gasch	i i	Name and Addres	-	e, P.A.	4739 Baltim Hyattsville				
*	Physician/ Medical	10	23a. Part 1. Enter the disease, or complishock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)	e cause on each lin 4000	A C	the mode of dying	g, such as cardiac o	or respiratory arres	20N	Approximate Interval Between Onset and Death			
	Examiner	70	Dut to (or as a consequence of): Sequentially list conditions, if any leading to immediate if any leading to immediate.										
	cuted nd :ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	a consequence	ce of):	RE	DE	orte	200				
0	ificate be executed g physician and as the burial-transit	cal E	resulting in death) Last	Due to or as a consequence	ce of):								
8760		Medical	IF FEMALE:										
Box 6	The law requires that the death cert ate has been signed by the attendir page 2 should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deatl 9 ☐ Unknown	eath 3 🗌	Ectopic pregnanc Other (specify)	у		23d. Date of delive Month	ery Day Year			
ds, P.O.	v requires that the by the by should be detact	by	Part II. Other significant conditions cor	ntributing to death but not resultin	ng in the un	derlying cause giv	en in Part 1.	23e. Did tob	acco use coptribute to the	ne cause of death?			
of Vital Records,	The law rec cate has bee page 2 sho	Completed						24a. Was an autops perform 1 🗆 Yes 2	prior to condeath?	osy findings available mpletion of cause of			
/ital	yslcian: The is certificate director, pag	Be C	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	10 1 1 1	Othe	r: Check		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				
n of V	ng Ph fter th meral	cate: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	b. Time of injury	28c. Injury work	at	28d. Describe ho	nce 6 Other (Specify w injury occurred				
Division	al or Atter s arter dea I Director d in by the	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	, farm, stre	et, factory, office		28f. Location (Str City or Town,	eet and Number or Rural , State)	Route Number,			
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu	Medical	(Check 2 Medical Examin	cian: To the best of my knowledger: On the basis of examination and Practioner: To the best of my knowledger.	d/or investi	gation, in my opinio	n, death occurred a	t the time, date and	d place, and due to the cal	use(s) and manner stated.			
	North To t		29b. Signature and title of certifier	Mi)	29c. License	number	25	9d. Date signed (Month, I	Day, Year)			
45	10+1		30. Name and address of person who ro	mpleted cause of death (Item 23a	a) (Type, Pr	in4)600	A	nou	TON	Lee 1			
K	Stat	e.	31. Date filed (Month, Day, Year)	32. Registrar's Signature		-JAW	ent	prta	K(M)	1040			
	Registra		DEC 2 7 2011 A.	we by Again									

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2011 Physician/ Month 12 08 Roberta 4:59 P^M Lorraine Roberts Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5812 Main Street <u>Oueen Annes</u> Oueenstown Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2 X (Month, Day, Year) 08-08-1943 Maryland 216-40-4574 68 Director Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f shorevent, the Medical Examiner must be notified at 10a. State Director 1 Yes 2 No Oueen Annes Md. Queenstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 5812 Main Street 21658 USA . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify Specify: Black 3 Widowed 4 Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) 2 should be filed within 72 h h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Seafood 12 S Fishery Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ Cornelius Griffin Ellen Handy George Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Terri Sorrell, Daughter 11, Grasonville.Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 12-17-11 4 Donation 5 Other (Specify) Gouldtown Cem. Centreville, Md. Signature of Funeral Service License 22. Name and Address of Facility Bennie Smith Funeral Home well Dover Street, Easton, Md. 426 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Meta Pnysician/ Ouzars disease or condition resulting in death) Stax Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury requires that the death certificate be executed burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Was an autopsy performed? Hospital or Attending Physician: The law 24 hours after death. death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide
Homicide Investigation 24 hours after death Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 🚈 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within . 3 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

Da

State Registrar 30 Name and address

4

DHMH 17 Rev 7/2009

cause of death (frem 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 42765 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Roswitha Elizabeth Reisinger 2011 11:40 p M December Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 577-54-1767 Director 1 ☐ M 2 ☐ XF Oct. 26, 1935 Germany 76 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d, Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 Yes XX No Rockville MD Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20852 Germany 263 Congressional Lane, #101 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give ģ White 1 Yes 2 No Specify: Specify: 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15, Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Sales Clerk Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked o ည Heinz Reinhardt Maria Westerhof 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 s at of Health a 4 Martha Court, Rockville, MD 20852 Annette U. Reisinger/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott cemetery, crematory or other place) № Burial 2 Cremation 3 Removal from State Dec. 21, Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Home Inc. ilver Spring Francis J. Collins Funeral 500 University Blvd. W., St disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury attending physician and for use as the buriat-transit death certificate be executed that initiated events Due to (or as a consequence resulting in death) Last Physician/Medical ves, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) Month Year Day Pregnant a ☐ Yes ∠⊾ ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ♣ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy performed? Yes 2 No To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 X No မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 X Natural 5 Pending work? 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Acritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier MoleCular D. Rockville, MD 20850 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAYED ELS AYYA'D Tollo Make

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

Please Type or Print in Black Indelibled Pk. E929re Alb Coppiest Are Legible. State of Maryland / Department of Health and Mental Hygiene 42766 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ RICHARD LIONEL REISH, JR. DECEMBER 2011 6:40 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5675 LANGFORD BAY ROAD CHESTERTOWN KENT Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Hours (Month, Day, Year) 11/04/1949 WASHINGTON, D.C. Director 194-42-2669 62 Usual Residence of Decedent í show 10a. State 10b. County 10c. City, Town or Location with the Maryland the Medical Examiner must be notified at 10d. Inside City Limits Director 28a-f 1 Yes 2 No KENT CHESTERTOWN MD 10e, Street and Number 10f. Zip Code ö 10g. Citizen of What Country? 23a Funeral 5675 LANGFORD BAY ROAD 21620 UNITED STATES items ? hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married 'natural", or ð Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 🗆 Widowed 4 🗆 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) COMMERCIAL PRINTING SALESMAN PRINTING and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. traumatic RICHARD LIONEL REISH. SR. JANE PERKINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5675 LANGFORD BAY ROAD CHESTERTOWN, MARYLAND 21620 LINDA REISH / WIFE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) CHESAPEAKE CREMATION 12/13/2011 STEVENSVILLE, MARYLAND 21. Signature of Funeral Service License 22. Name and Address of Facilit Delho 23a. Part 1. Enter the disease, one omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on euch line. Approximate Onset and De Interval Between Immediate Cause (Final Physician/ months disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to for as a consequence of that the death certificate be executed the burial-transit Due to (or as a consequence of): ending physician use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ned by the atter detached for u in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death P.O. 23e. Did tobacco use contribute to the cause of death? ᇫ Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perform death? 25. Was case referred to med Be 26. Place of Death (Check only one) examiner? 2**X** No Other: 1 🗌 Yes မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 \(\sum \) Nursing Home Residence 6 After this funeral 28a. Date of injury (Month, Day, Year) Manner Death Certificate: 28b Time of 28c. Injury at 28d. Describe how injury occurred Vatural 5 Pending work n 24 hours after death.

e Funeral Director: Aft
bleted filled in by the fur 1 Tes 2 🗌 No Accident Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🖂 within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12 201 15 erson who completed cause of death (Item 23a) (Type, Print) ms 32. Regis State

Registrar

Please Type or Print In Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar	,	Ċ	ertificat	e of	Death			Re	eg. No.	UI	1 7210
Physici		Decedent's Name (First, Midd								. Date of Deat	h	,	3. Time of Death
Medical Exam	iner	A. Frank, Name (Grant Lands (Co.)	Brian An		hoade					Month December			1428 hrs
		4a. Facility Name (if not institution 148 Carters Mill Road		nber)		46	Elkton	or Location of			4c. County of		
Funeral		5. Social Security Number		7. Age (In yrs.	last birthd	ay)	If Under 1 Ye			8. Date of Bir	th (MM/DD/YYYY	9. Birt	hplace (State or
Director		213-35-2075	1XM 2F	20		Yrs.	Months Da	ys Hours	Min.	11/12	/1991	Cou	untry)Delaware
ROY		Usuel Residence of Decedent 10a State 10b County		Inc. Cit	y, Town or	Locatio	2						404 1
		Maryland Cec	∴ 1				''						10d. Inside City Limits 1 Yes 2 No
Maryland 28a-f show d at ooce.	흕	10e. Street and Number	<u>TT</u>		E1kto		10f. Zip Code			140	ng. Citizen of Wh	not Cour	
5-0036 led within 72 hours after death with the Maryland tygiene. other thao "natural", or items 23a or 28a-f sho the Medical Examiner must be ootfifed at goose.	Director	148 Carters M	ill Pood				2192	1					
with tl		11. Marital Status	12. Was Dece	edent Ever in I	U.S. 1	3. Was	ZI9Z Decedent of H		nin? (Spec	cify Yes or No.	United		ates can Indian, Black,
r item	Funeral	1 X Never Married 2 M	arried Armed Fo	rces?			s, specify Cuba				White		our main, black,
after o	by F		orced If Yes, Give Year			1 📗 🕥	∕es 2 X N	o specify:			Specify:	Whi	ite
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5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12)	College (1-	4 or 5+)	1		_	6. DO NOT	436 C(C(-)			
15-00; lled with Hygiene, d other th	E	17. Father's Name (First, Middle,	Last\		<u> </u>	Stuc	lent	40 Marks	ta Nama (F		High		001
	Be C	Robert Michael	•							Tormo)	
D 21215 should be fill and Mental H 7 is marked .	ToE	19a. Informant's Name/Relations			19b. I	Mailing A	Address (Stre	et and Num	per or Rur	al Route Num	ber, City or Tow	n, State,	Zip Code)
E 0 . 0 E	1	Patricia Rhoad	les/Mother		14	8 Ca	rters l	Mi11]			n, MD 2		
ore, N es I and or Health If item		20a. Method of Disposition 1 Burial 2 X Cremation	3 Permoval fro	20b.	Place of D	Dispositi	on (Name of ce	emetery,		Date mber	20c. Location -	City or	Town, State
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Baltimo permit. Page Department Important: injury or otl		21. Signature of Funeral Service	Licensee	-		22. Na	me and Addres	s of Facility	1110	ks Hom	e for Fi	iner	als, P.A.
		230 Bort Enter the disease or	S. Tul	مد		1	.03 W. S	Stock	ton S	treet,	Elkton,	, MD	21921
Physician /Madical		23a. Part I. Enter the disease, or failure. List only one cause	on each line.									art	Approximate Interval Between Onset and
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376(ficate g phys s the b		IF FEMALE: 23b. Was decedent pregnant in th	23c. If yes, or		_	7					23d. Date of		
Box 68's death certification attending of for use as.	cia	past 12 months?	1 Live bir	นา nt at time of d	eath 5	=	death 3 r (Specify)	Ectopic	pregnanc	у	Month	Di	ay Year
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P.O.	by P	Part II. Other significant conditi	ions contributing to	death but not	rasulting in	the und	derlying cause	given in Pa	rt I.				he cause of death?
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of V Phys rer thii	P	1 ✓ Yes 2 No 27. Manner of Death	28a. Date o	patient 2	ER/Outpa 28b. Tim			ary at Work			Residence 6		Scene
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Division tal or Atteodi rs after death. al Director: A led in by the fu	fical	. 🗖	OD - Dines	2-27-11 of Injury - At h	nome, farm	414 , street,	factory, office I				treet and Numbe	er or Rur	al Route Number, City
Division of Vital Records, P.O. Box 68 Hospital or Atteoding Physiciae: The law requires that the death certif 14 hours after death. Functal Director: After this certificate has been signed by the attending ely filled in by the funeral director, page 2 should be detached for use as	Certification:		mined (Specify)	Res	idenc	e				or Town, St	ate) 148 Ca	irte	rs Mill Rd.
e Hos 24 hc e Fuo etely f		29a. Certifier 1 Certifying Ph	ysician: To the best	of my knowled	dge, death	occurre	d at the time, d	ate and pla	ce, and du	e to the cause	e(s) and manner	as state	d.
Division To the Hospital or Atteot within 24 hours after death To the Fuocral Director: completely filled in by the	ledical		niner: On the basis of and manner sta	examination a ted.	and/or inve	stigation			curred at th	ne time, date a	and place, and du	ue to the	ceuse(s)
	Σ	29b. Signature and title of certifier	111	1	A		29c. Licens				29d. Date signe		
						(O.C.	M.E.			December 2	28, 20°	11
		30. Name and address of person Zabiullah Ali, M.D.	who completed cause Assistant Medica	,	,	N. Bal	timore Stre	et. Baltir	more M	D 21223			
		31. Date filed (Month, Day Year)		strar's Signat									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 21, 2011 8:20A. M Physician/ Francis Allen Sowers Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's 8711 49th Avenue College Park Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours 1**X** M 2 □ F Maryland 219-34-5907 74 June 18, 1937 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits at the Maryland Director ns 23a or 28a-f s must be notified Prince George's 1 X Yes 2 □ No College Park Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be flied within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 c any injury or other traumatic event, the Medical Evandance. Funeral 8711 49th Avneue 20740 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 100 100 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. White Specify: If Yes, Give Year or Dates 1960-1962 3 Widowed 4 Divorced 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Trucking Co. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ٥ Mildred Pauline Sines Walter Clarence Sowers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8711 49th Avenue College Park, Maryland 20740 Beverly L. Sowers -wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Garrett Co. Memorial Cons. 12/28/2011 1 X Burial 2 Cremation 3 Removal from State Oakland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bonald V: Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ End Stage Debility disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): Exami executed the burial-tran Due to (or as a consequence of): resulting in death) Last physician Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 L. Fold Seath in the past 12 months? Month Day Year Yes 2 No ed by the a 9 Unknown 1 ☐ Yes ∠ ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Paralysis Agitans s been signed b should be deta 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? 1 ☐ Yes 2 🕅 No 25. Was case referred to medical funeral director, Be examiner? Hospital Other: 1 ☐ Yes 2 🕅 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 K Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending injury after death.

Director: Aff
in by the fur 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

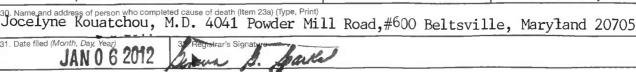
24 hours a To the Hosp within 24 ho To the Fune

only one)

29b. Signature and title of certifier

Josetyne

31. Date filed (Month, Day, Year, JAN 0 6 2012



Kouarchou, mD

State

Registrar

163748

29d. Date signed (Month, Day, Year)

December 21, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 9:36 p 2011 Lillian Irene STOUFFER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington 300 Key West Drive Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov • 23 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 M 2 X F 1913 Maryland **Director** 98 214-09-1923 Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location with the Maryland notified at Director 1 🔀 Yes 2 🗌 No Maryland Washington Hagerstown 10f. Zip Code 10o. Citizen of What Country? or 10e, Street and Number Examiner must be Funeral items 23a 21740 USA 300 Key West Drive death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ö 1 Never Married 2 Married þ filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: If Yes, Give Year or Dates "natural", White 3 X Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry al Hygiene. life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Teletype Operator Communications ith and Mental Hygie

27 is marked other
traumatic event, the Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Page 1 and 2 should be Howard Franklin Stickler Susie Elizabeth Krunkleton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trau 300 Key West Drive, Hagerstown, Maryland 21740 <u>Dona L. Nikirk - Daughter</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 12/28/2011 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Hill Cemetery Minnich Funeral Home . Signature or Funeral Service Licens 22. Name and Address of Facility E. Wilson Blvd. Hagerstown, Maryland 21740 415 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in the line. Approximate Interval Between Immediate Cause (Final set and beath Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine burial-transi and attending physician I for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months 1 Yes 2 No signed by the atte Month Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an tate has page 2 s autopsy perform Yes 2 24 hours after death. Funeral Director: After this certificate 25. Was case referred to per cal 26. Place of Death (Check only one) funeral director, Be examiner? Hospital မ 1 \square Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Mann Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred injury 5 Pending Natural 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 3 only one) 29b. Signature and title of certific 2011 665

DHMH 17 Rev 7/2009

State Registrar

death (Item 23a) (Type, Print)

120.

30. Name and address of person who completed cause of

31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1,2770 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month December Ruth Mae SPURDENS 2100 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Western Maryland Health Care System Cumberland Allegany Social Security Number If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign **Director** 1 🗆 M 2 💢 F 121-38-1401 62 Oct. 11 1949 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Cumberland Maryland Allegany 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? must be 23a Funeral 10301 Christie Road, NE 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 0 þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White "natural", Specify Completed 3 Widowed 4 N Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 10 Care Taker Salvation Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ဂ William Burley Spence Evelyn Isabell Hardy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 sof Health William Hahn - Son P.O. Box 345, Marion, Pa. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If it any injury or o once. 1 X Buriai 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cedar Lawn Mem. Park 12/29/2011 Hagerstown, Maryland 21. Signature of Funeral Service Loensee 22. Name and Address of Facility Minnich Funeral Home ames T. Spices 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Pa . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions it any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequ Examir burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day 1 ☐ Yes ∠ ☐ 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 2 🗌 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 ☐ № Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 S Natural (Month, Day, Year) 5 Pending 1 Yes 2 No 2 Accident 24 hours after death Funeral Director: Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 210 23371 30. Name and address of person who completed cause of death(Item 23a) (Type, Print)

Dr. Qamar Zaman 12502 Willow Brock Rd. Cumberland, MD 21502 31. Date filed (Month, Day, Year, State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jerome Sampson December 2011 5:02 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Doctors' Comunity Hospital Lanham If Under 1 Year 7. Age (In yrs. last birthday) **Funeral** If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Min. 10-16-1947 Director Clinton, NC 579-62-2006 Usual Residence of Decedent or 28a-f shov notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Prince George's New Carrollton 1 X Yes 2 No 10e. Street and Number 10g. Citizen of What Country?
United States be Funeral "natural", or items 23a 6405 Kaslo Street 20784 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. ٥ 1 Never Married 2 Married ☐ Yes 2**X** No Yes, Give Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2X No Specify: Completed 3 Widowed 4 Divorced Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) other than Metropolitan Meat/ Elementary/Seconday (0-12) College (1-4 or 5+) Seafood & Poultry Truck Driver Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file nent of Health and Mental F ant: If item 27 is marked o Thomas L. Wilson, Sr. Alice Freeman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6405 Kaslo St New Carrollton, MD 20784 Ynonne R. Sampson (Companion) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Fort Lincoln Cemetery 12/30/2011 Brentwood, MD 21. Signature of Funeral Savice Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home Kuly Brentwood, MD 20722 3401 Bladensburg Rd. hompso-23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Sepsis disease or condition resulting in death) Medical Examiner Irchemic Cholitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Bacteral Pertoutis signed by the attending physician and d be detached for use as the burial-transi Soartane aus fo the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last with Partal Hypertension Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ☐ Pregnant at time of death ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has 1 TYes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur 2 No ☐ Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie MDD 53066 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD. 8909 Old Branch Quenue, Clinton, MD. 20735 Jamaken 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ FOI	State of Marylan	d / Depa	artment of H	ealth and N	lental Hygie	ene	
			_ State Registrar		Cer	tificate of D	eath	Reg	. No. 20	1, 1,2772
	Physicia	m/	1. Decedent's Name (First, Middle, Last)					2. Date of Death	Day Oli Year	3. Time of Death
	Medic		Charles L. Stull					Dec. 23	, 2011	12:00 P M
	Examir	ner	4a. Facility Name (if not institution, give stree	,		4b. City, Town, or I			4c. County of Deat	
	2		5517 Berkley Manor 5. Social Security Number 6. Sex	7. Age (In yrs. Ia	est hirthday)	Churcht If Under 1 Year		8. Date of Birth	Anne Arun	thplace (State or Foreign
	Funeral Director			1 2 □ F 80	Yrs.	Months Days	Hours Min.	(Month, Day, Ye May 13,	931 Fred	lerick, MD
		١.	Usual Residence of Decedent					-		COLLECT IID
	/land f sho ed at	향	10a. State 10b. County		, Town or Loc					10d. Inside City Limits
	28a-	ire	MD Prince Geo	rge's Hyat	tsvill					1 ₺ Yes 2 □ No
	th the	al	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	-
	ims 2	Funeral Director	4532 Buchanan Stree 11. Marital Status 12.	Was Decedent Ever in U.S	13 V	20781 Vas Decedent of His	spanic Origin? (Spe	ecify Yes or No-	14. Race - Ame	
(0	er de or ite niner		1 Never Married 2 M Married	Armed Forces? 1 Yes 2 X No	l It	Yes, specify Cuban	, Mexican, Puerto		Black, White	
ဇ္ထ	rsaft iral", Exal	ed t	3 🗆 Widowed 4 🗆 Divorced	If Yes, Give Year or Dates.	1	☐ Yes 2 🖾 No	Specify:		Specify:	White
21215-0036	2 hou "natu	Completed by	15. Decedent's Educa (Specify only highest grade of			lent's Usual Occupa		ing 16	6b. Kind of Business	Industry
2	hin 7	E O		College (1-4 or 5+)	Ìife. Do	O NOT use retired)	3		T C+11	Contractors
Ż	d with the rut, the	Be C	17. Father's Name (First, Middle, Last)		Contr	-	19 Matharia Nam	e (First, Middle, Ma		Contractors
and	be file ental I ked o c eve	욛	Mehrl Victor Stull			i i		Rebecca	·	
Maryland	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho is marked other than "natural", or items 2a or 28a-f sho is marked other than "arumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type,	Print)	19b. Mailin				ty or Town, State, Zij	o Code)
Š	d2sh altha 27is	Ш	Lois E. Stull / Wife	e	1				le, MD 20	
ore,	1 and of Hei	l	20a. Method of Disposition		lace of Dispo	sition (Name of natory or other place		Date 20	c. Location - City or	Town, State
Ē	Page nent ant: Il		1 ☐ Burial 2 🖺 Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify)	Hovar Horri Grace		tan Cremat		7/11 A1	exandria,	Virginia
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show array injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee		22	. Name and Address	s of Facility			imore Ave.
<u> </u>	20 5 8 9		Charle Bar	Regers	Ga	asch's Fu	neral Hor	ne, P.A.	Hyattsvil.	le, MD 20781
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one care		n. Do not ente	er the mode of dying	, such as cardiac	or respiratory arrest	,	Approximate Interval Between
, F	hysician/	1	Immediate Cause (Final disease or condition	Right CVA						Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a consequ	,					
		ē	Sequentially list conditions, b	Hypertensio Due to (or as a consequ						
	nsit	Examiner	if any, leading to immediate Cause (Disease or iinjury							
	ite be executed hysician and he burial-transit	ĸ	that initiated events c. a resulting in death) Last	Due to (or as a consequ	ence of):					
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6876	ificate ng ph as th	Med	IF FEMALE:							
Ø ×	eath certificat attending ph I for use as th	Physician/Me	23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregna 1 Live Birth 2 Feta	II death 3	Ectopic pregnancy	/		23d. Date of de	
Вох	deat the at red fo	/sici	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at time of c 9 ☐ Unknown	death 5	Other (specify)			Month	Day Year
P.O.	es that the des signed by the a be detached f		Part II. Other significant conditions contril	buting to death but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ν, σ	res that signed d be det	Completed by								robably 4 🖾 Unknown
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ပ္မ	e law has ge 2 s	lg l						autopsy performe	prior to	completion of cause of
<u> </u>	ician: The Is certificate ha ector, page		25. Was case referred to medical			26 Pla	ce of Death (Chec		X No 1	s 2 No
Division of Vital Records,		To Be	examiner? 1 Yes 2 X No	pital:	EB/Outpaties	Othe	r.		ce 6 🖾 Other (Spec	Daughter's
of	g Physer this er this eral di			28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury	at	28d. Describe how		Hesicence
o	Attending or death. ector, After by the funer	lical	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Tear)	Hijury	M 1 🗆	yes 2 □ No			
/ISI	r Atte ter de recto	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		eet, factory, office		28f. Location (Stree	et and Number or Ru State)	ral Route Number,
á	ital or urs afte ral Dire									
	Hospital 24 hours a Funeral C	Medical	(Check 2 Medical Examiner:	n: To the best of my knowl On the basis of examination	and/or invest	tigation, in my opinior	n, death occurred a	t the time, date and	place, and due to the	cause(s) and manner stated
	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director, After thin completed filled in by the funeral or	ž	only one) 3 Certifying Nurse Pr 29b. Signature and title of certifier	ractioner: To the best of my	knowledge, o	death occurred at the 29c. License			use(s) and manner as	
	F ≥ F ŏ		· Soulh	_			76961	250	12/24/11	1
			30. Name and address of person who comp	pleted cause of death (Item	23a) (Tvne F		14141		107/11	
Q	0		Salome Hawkins-Cole				way, Balt	imore, M	D 21216	
Ĭ	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar Signat		,				
			DEC 2 7 2011 /2	where B. A	- Cur					

DHMH 17 Rev 7/2009

11-09667

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

homas Simms		1- For State Registrar	State	e of Maryland		artment of rtificate of		nd Mental I	_	Reg. No.	201	1 4277
Physici Medical Exami	an/	Decedent's Name (I THOMAS		est)					2. Date of De Month Decembe		Year	3. Time of Death 0513 hrs
\$		4a. Facility Name (if n	not institution, gi)	4	b. City, Town, o	or Location of Dea		4c. Cour	nty of Death	
Funeral Director		5. Social Security Nun	mber 6. S		ge (In yrs. I	ast birthday) Yrs.	If Under 1 Ye	ar If Under 24H	rs. 8. Date of B in. 02/21	irth (MM/DD/Y)	YYY) 9. Birt Foreig	thplace (State or
h		Usual Residence of De	ecedent	- M 2 F		. Town or Location			102/22/			
nd show any	_		Db. County PRINCE (GEORGES		RT WASH						10d. Inside City Limits 1 X Yes 2 No
Maryland r 28a-f show ed at once.	Director	10e. Street and Numb					10f. Zip Code			10g. Citizen of		•
eath with the Maryland items 23a or 28a-f sho ust be notified at once		1113 ELWIN		12. Was Deceden		.S. 13. Was	2074 Decedent of H	ispanic Origin? (Specify Yes or N		ace - Ameri	ES can Indian, Black,
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f sho natic event, the Medical Examiner must be notified at once	by Funeral	1 Never Married 3 Widowed		d Armed Forces' 1 Yes 2 d If Yes, Give Year or Dates:		1	Yes 2 N			Specia	/hite, etc. fy: BLA	
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21215-(1036 wild be filed within 72 hours after d Mental Hygiene. marked other than "natural", or c event, the Medical Examiner m	å	FREDICK S	SIMMS					EDNA BE	ACH SIM	MS		
MD 2. d 2 should lith and M m 27 is munatic c	7	19a. Informant's Name BERNICE D.						et and Number o				Zip Code) ND 20744
		20a. Method of Dispos		Removal from St	ate (Place of Disposit crematory or oth	er place)		Date	20c. Location	on - City or	Town, State
Baltimore, permit. Pages 1 at Department of He Important: If ite		4 Donation 5 21. Signature of Funer			HER	TAGE MEM	RIAL CEM	ETERY O1/ ss of Facility UNERAL F	03/2012	WALDO	RF, M	ARYLAND
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Sox 6876 leath certificate e attending phy for use as the b	ian/N	IF FEMALE: 23b. Was decedent pre past 12 months? 1 Yes 2 No		23c. If yes, outcome 1 Live birth 4 Pregnant at 1 9 Unknown		2 Feta	al death 3 er (Specify)	Ectopic pregi	nancy	23d. Date Month	of delivery D	ay Y ear
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Vital Rec ysician: The l his certificate l director, page	æ	25. Was case referred examiner?		Hospital: 1 🗸 Inpatie	ent 2	ER/Outpatient		e of Death (Chec		Residence 6	Other:	
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Division spital or Attent hours after death meral Director:	ertification	2 Accident 3 Suicide 6 4 Homicide	Investigat Could not determine	be 28e. Place of Ir	ijury - At ho	ome, farm, street	, factory, office	building, etc.	28f. Location (or Town, S		mber or Rur	al Route Number, City
Di To the Hospital within 24 hours a To the Funeral I	Medical C			clan: To the best of m r:On the basis of exa and manner stated.								
	ž	29b. Signature and title	e of certifier	alla	v		29c. Licen O.C	se number .M.E.		29d. Date si Decembe		th, Day, Year)
		30. Name and address Carol Allan, M		completed cause of c ant Medical Exar		•	more Street	, Baltimore, N	/ID 21223			
St Regist	ate rar	31. Date filed (Month, I		32. Registra		A has	41					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 12:59 PM essie Emm 2011 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Annapol Arundel Arunde If Under 24 Hrs If Under 1 Year Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 230-56-8378 **Director** 1 M 2 X F 68 Va. 4-26-1943 28a-f show ina State ral", or items 23a or 28a-f shore Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Md eens town 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. an "natural", or Medical Examin by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumation. Elementary/Secondary (0-12) College (1-4 or 5+) Keeper D WD D Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnarne) 2 Joseph anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Singletary Queens town Md. 2 1658 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 \square Burial 2 \bowtie Cremation 3 \square Removal from State rematory LLC 12-14-11 Dover, Delaware 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Iddress of Facility
Bennie SMit
426 Dover S Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Vontric ARREST Physician/ disease or condition resulting in death) Medical Examiner CARDOM TOPATH Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) and -trans that initiated events resulting in death) Last Due to (or as a consequence of) physician a s the burial-1 Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 as IF FEMALE: ase 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ò in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death the 9 Unknown signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Anoxic Enephelopeth Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? CARDIOMIUPATHY 24a. Was an has perform this certificate Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 27 No 1 Inpatient 2 ER/Outpatient
Date of injury 28b. Time of Other: ျ 4 Nursing Home 5 Residence 6 Other (Spec Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred hin 24 hours after death. the Funeral Director: After apletely filled in by the funer 1 Natural 2 Accident (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation M 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certi 29c. License number 219 s of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre Pat

DHMH 17 Rev 06-2011

State Registrar Park

Annapolis

M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 9:09 pM Patsy Elizabeth Saunders 2011 December Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Holy Cross Hospital Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 578-42-2905 Director 1 □ M 2 🍱 F 78 March 7, 1933 Washington, DC Usual Residence of Deceden 28a-f show 10d. Inside City Limits at 10a. State 10c. City. Town or Location Director must be notified 1 🗌 Yes 2 🏝 No MD Montgomery Silver Spring 10g. Citizen of What Country? the 10f. Zip Code 5 10e. Street and Number 23a Funeral death with 3108 Weller Road 20906 USA or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14, Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 Black If Yes, Give Year or Dates 1 Yes 2 No Specify: 1 and 2 should be filed within 72 hours after by Health and Mental Hygiene.

item 27 is marked other than "natural", other traumatic event, the Medical Exar 3 ☒ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Shipping Handler United Wholesaler Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Freddie Clayton Florence Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Page 1 and 2 sl ment of Health a 3108 Weller Road, Silver Spring, MD 20906 Marian D. Bish/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Important: If it any injury or o once. 1 🗵 Burial 2 🗆 Cremation 3 🗆 Removal from State crematory or other place) Dec. 20, e of Heaven Cemetery 4 Donation 5 Other (Specify) Silver Spring, MD 21. Signature of Funeral Service Francis J. Collins Funeral Home Inc. 500 University Blvd. W, Silver Spring MD 20901 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End-Stage Renal Disease Phaistolan/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Fibrillation Se wentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the attending physician and that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Year detached for Month 4 ☐ Pregnant at time of death g ☐ Unknown g Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension, Anemia, Anal Cancer 1 Yes 2 No 3 Probably 4 thknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has performed' 1 Yes 2 No Yes 2 X No the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 Yes 1 ☐ Inpatient 2X ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: within 24 hours after death.

To the Funeral Director: After 1 🖾 Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signa

FArah Abdulsalam, MD

19

31. Date filed (Month, Day, Year,

7-0395

1500 Forest Glen Road, Silver Spring, MD 20910

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra AMEND#20 openFH, 12/20/11; BMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^{Day}, Mary December 2011 **p** M Serra 7:30 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Renaissance Gardens at Riderwood Village Silver Spring P.G. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)

Italy 8. Date of Birth **Funeral** 059-12-0545 1 🗌 M 2 🔀 F Months Hours Director 91 Dec. Usual Residence of Decedent 28a-f show 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Prince George's 1 🗌 Yes 2 🔀 No Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3160 Gracefield Road 20904 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 SpecifyWhite 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event the Manani injury or other traumatic event the Manani life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Benedetto Freccini Vita Bonello 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dave Serra/Son 9384 Steeple Court, Laurel, MD 20723 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Arlington National 4 ☐ Donation 5 ☐ Other (Specify) Jan 12, 2012 Arlington, VA emeterv Francis J. Collins Funeral Home Inc. 500 University Blvd.W., Silver Spring,MD 20901 23a. Part 1. Enter the disease, or complications that cause. The leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ a Arteriosclerotic Cardiovascular Disease disease or condition yrs Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exam the burial transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year signed by the a 2 No 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performe 1 Yes 2 No the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Hospital or Attending Natural Accident (Month, Day, Year) 5 Pending after death.

Director: Aft 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined building, etc. (Specify) within 24 hours a

To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 📈 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of 29c. License number

Registrar

10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Julaine Harding, CRNP

DEC 19 2011

31. Date filed (Month, Day,

112633

3110 Gracefield Road, Silver Spring, MD 20904

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 42777 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Patricia F. Shettel 2316 December 2011 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomeru Suburban Hospital Bethesda Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Hours (Month, Day, Year) Davs 187-26-8738 1 🗆 M 2 🗶 F 77 11/11/1934 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a State 10d. Inside City Limits by Funeral Director 1 Yes 2 X No Maryland Rockville Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20853 U.S.A. 14102 Artic Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black White etc. 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Director of Research Support Elementary/Secondary (0-12) College (1-4 or 5+) Research Organization Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, ပ Marcella Sakalowski Jay Rogansky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harris H. Shettel - Spouse 14102 Artic Avenue, Rockville, Maryland 20853 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1

Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Parklawn Memorial Pk. 12/18/2011 Rockville, Maryland . Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 Approximate Interval Between 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Physician/ Medical Examine

Funeral

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Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i

Medical

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with the Maryland

Page 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

ending physiclan suse as the burial-24 hours after deeth.

Funeral Director: After this etely filled in by the funeral di

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

	disease or condition resulting in death)	a <u>Cardiopulmonary Arrest</u>		
		Due to (or as a consequence of):		
Examiner	Sequentially list conditions, if any, bedding to increadate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Pneumonia Due to for as a consequence of): Due to (or as a consequence of):		
Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	d	23d. Date of de Month	slivery Day Year
Completed by PI	Part II. Other significant conditions co	ontributing to death but not resulting in the underlying cause given in Part I.	autopsy prior to	
Con				s 2 No
Be (25. Was case referred to medical examiner?	26. Place of Death (Check	k only one)	
10	1 Yes 2 XNo	Hospital: 1 【X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Ho	me 5 Residence 6 Other (Spe	cify)
	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) injury work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred	
Aedical Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Re City or Town, State)	ıral Route Number,
dedica	(Check 2 Medical Exami	ician: To the best of my knowledge, death occurred at the time, date and place, ar ner: On the basis of examination and/or investigation, in my opinion, death occurred at e Practitioner: To the best of my knowledge, death occurred at the time, date and place.	the time, date and place, and due to the	cause(s) and manner stated.

29c. License number

D70241

8600 Old Georgetown Road, Bethesda, Maryland 20814

29d. Date signed (Month, Day, Year)

December 16, 2011

State Registrar

within 2

29b. Signature and title of certifie

Shanthi Murgesh Nadar,

31. Date filed (Month, Day, Year)
DEC 19 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ P^{M} MARIE SASSCER 2011 DEC 1:45 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGE'S Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Min. (Month, Day, Year) Hours Director 578-16-1266 1 □ M 2 🕱 F Yrs. 98 SEPT.28,1913 WASHINGTON, DC show or 28a-f shov notified at 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No PRINCE GEORGE'S MD. UPPER MARLBORO 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 6201 CROOM STATION RD. 20772 U.S.A. filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? þ Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. If Yes, Give Specify. 3 X Widowed 4 □ Divorced Completed Year or Dates WHITE the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working al Hygiene. d other than " life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10 SECRETARY LAW OFFICE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F ည AUGUST permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic , once. SACHS traumatic MARGARET ZELLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FREDERICK SASSCER III/SON 6205 CROOM STATION RD., UPPER MARLBORO, MD. 20772 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) TRINITY CHURCH CEM. 12-19-2011 UPPER MARLBORO, MD. 21. Signature of Funeral Service Licensee ess of Facility
FUNERAL HOME & CREMATORIUM, P.A. M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Death
2 heurs shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Uys Vythmia disease or condition resulting in death) Medical Examiner Thour_ Cardio aenic Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury cardiovascular desease requires that the death certificate be executed physician and streets the burial treets that initiated events resulting in death) Last Physician/Medical pertension Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) detached for in the past 12 months?
1 Yes 2 No Month Day Year 1 ☐ Yes ∠ in 9 ☐ Unknown Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pancreatiti Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy Advanced performed death? age 2 🗆 No Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 IDOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier npletely Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar (cin

31. Date filed (Month, Day, Year)

6-

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Champaloux MD.

D049042

upper Marcharo, MD

SGECTER, MOLLY

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	Exami	ner	4a. Facility Name (if			nber)				r Location of Dea	ith		4c. County of	Death	1		
-			Suburban 5. Social Security Nu		Sex I	7 100 /10 10	ra last hirthday		hesda der 1 Year				Montgo				_
	Funeral Director		577-12-8 Usual Residence of	483	1 M 2 T	92	rs. last birthday) Yrs.	Month		If Under 24 Hr Hours Mir		f Birth Day, Yea 9-191	9	B. Birth Cou	nplace (State (ntry) Net	te or Foreig V Yorl	
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	ems r mu	Funeral	9901 Bar	Stow CL.	-	dent Ever in	U.S. 13. \			Ispanic Origin? (5	Specify Yes or						_
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	11. Marital Status										, etc.	,				
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Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burlal-tractor.	al Certificate:	4 Homicide	determined	28e. Place of	of Injury - At g, etc. (Spec	home, farm, stre ify)	et, factor	ry, office			n (Street a Town, Stai	nd Number of te)	r Rura.	Route Nur	mber,	
	Hosp 24 hou Fune fed fil	Medical	(Check 2°L	Certifying Phy Medical Exam	ilner: On the basis	s of examinat	ion and/or investi-	gation, in	my opinio	 death occurred 	at the time da	te and place	e and due to	theca	use(s) and r	manner stat	ed
	thin 2	ž	only one) 3 [29b. Signature and tit	□ Certifying Nur	se Practioner: To	the best of	my knowledge, de	eath occu	urred at the	time, date and pl	ace, and due to	the cause	e(s) and manne	r as st	tated.	1101 0100	_
	F 3 F 35		255. Olgitature and the	le or centiler	110			- 1	c. License			29d. D	ate signed (M	onth,	Day, Year)		
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	Registra		UEC	1 5 2011	Sen	a B	par										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State RegistraMEND#5perrINF, 12/22/11; BWW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 10,2011 Physician/ Month 5:15 pm Martha Shepherd December Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 13208 Sherwood Forest Drive Silver Spring Montgomery 7. Age (In vrs. last birthdav) Birthplace (State or Foreign Country) 5 Social Security Number 298 – 26 – 6330 If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Director 1 🗆 M 2 🎗 F 81 02/13/1930 Alabama Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Yes 2 X No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 13208 Sherwood Forest Drive 20904 U.S.A. death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. ō by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 Yes 2 X No Specify. Specify "natural", 3 X Widowed 4 □ Divorced Completed Black Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the 12 Clerk Health Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Abraham Griglen permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Mamie (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Shepherd - Daughter 13208 Sherwood Forest Drive, Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🕱 Removal from State Memory Gardens Cem. 12/15/2011 Colonie. New York 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licenses 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Multiple Myeloma disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence on e burial_etransit cernificate be executed and Due to (or as a consequence of): resulting in death) Last artending physician Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🕱 No Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 Yes 2 No Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 X No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury s after death.

I Director: Aff
ed in by the fu 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide within 24 hours after
To the Funeral Direct
Confidence of the part determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatura and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D..

Peter B. Sherer,

31. Date filed (Month, Day, Year) **DEC 1 5 2011**

D21910

3921 Ferrara Drive, Wheaton, Maryland 20906

December 12, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Year Robert Lee Shipp 8:58 A M December /Medical 2011 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5101 River Road Apt. Bethesda Montgomery If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth Social Security Number . Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 XM 2□ F Illinois 82 Yrs Director 330-24-7433 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

Int: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at MD Yes 2□No Montgomery Bethesda Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5101 River Road Apt. 1002 20816 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? World 1 ⊠Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 War 1 ☐ Yes 2 ☑ No If Yes, Give þ Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager Law Firm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marguerit Young Oscar Douglas ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Liza A. Shipp / Wife 5101 River Rd. #1002 Bethesda, MD 20816 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of
Important: If It
any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, DC Rock Creek Cemetery 4 ☐ Donation 5 ☐ Other (Specify) ek Cemetery 12/15/2011 | Washington, DC 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral er 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardial Infarction ∤Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Chronic Renal Failure Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the buriations Exam Diabetes Mellitus Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) □Yes 2□No the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed? 1 □Yes 2 ▼No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 Pending 1 ☐Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

State Registrar

DHMH 17 Rev 1/2001

completely f Medical

DEC 15 2011

29a. Certifier

(Check o

31. Date filed (Month, Day, Year)

of certifier.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven A. Burka MD 5530 Wisconsin Ave.

32 Registrar's Signature

one) 29b. Signature and title

🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D26457

29c. License number

Chevy Chase, MD 20815

29d. Date signed (Month, Day, Year)

December 14, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day LATOYA SMITH DEC 2011 8:03 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S 8026 LAKECREST DR. GREENBELT 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 1 □ M 2 🗓 F Months Davs Hours Min. FEB. 20 VIRGINIA Director 224-49-9207 29 982 Usual Residence of Decedent show 10a, State 10c. City. Town or Location must be notified at 10d. Inside City Limits Director 28a-f 1 √2 Yes 2 □ No MD. PRINCE GEORGE'S GREENBELT 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral items 23a 8026 LAKECREST DR. 20770 U.S.A. within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian the Medical Examiner Armed Forces? Black, White, etc. and Mental Hygiene. is marked other than "natural", or i 1 Never Married 2 Married ð Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify. 3 Widowed 4 Divorced Completed BLACK 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) DOCTOR MEDICAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) STAN CARSON PATRICE permit. Page 1 and 2 should to Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AVERY SMITH/HUSBAND 8026 LAKECREST DR., GREENBELT, MD. 20770 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) CHAMBERS CREMATORY 12-13-2011 RIVERDALE, MD. Signature of Euneral Service Licensee 22 Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A round M00091 CLEVELAND AVE. RIVERDALE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 18 MONTHS Immediate Cause (Final ⊖nysician/ MELANOMA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impuly that initiated events Examine Due to (or as a consequence of): and -that the death certificate be executed Due to (or as a consequence of): resulting in death) Last burial attending physician Physician/Medical Box 68760 the as IF FEMALE JSe 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 X Yes 2 No for TERMINATION Month Pregnant at time of death ed by the a 9 Unknown 9 Unknown P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐XNo 3 ☐ Probably 4 ☐ Unknown cate has been sig page 2 should be Completed 24a. Was an 24b. Were autopsy findings available Hospital or Attending Physician: The law autopsy prior to completion of cause of death? certificate Yes 25. Was case referred to medical 26. Place of Death (Check only one) director. Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify, Hospital: 1 \sum Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 2 Accident
3 Suicide thin 24 hours after death.

the Funeral Director; At mpleted filled in by the fu death Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24
To the I only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

ST., ROOM 186, BALTIMORE, MD.

1650 ORLEANS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32 Registrar's Signa

EVAN J. LIPSON,

DEC 1 5 201

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month JOSEPH **SPARAGNA** DEC 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death WRNMMC MONTGOMERY BETHESDA5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days 1 M 2 D F Hours Sept. 5, 1922 082-32-2338 New York 89 Director Yrs Usual Residence of Deceden ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d, Inside City Limits Direct Maryland | Montgomery Silver Spring 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3112 Gracefield Road, #PV122 20904 United States 12. Was Decedent Ever in U.S. Armed Forces? 1& Yes 2 ☐ No If Yes, Give 1940-1961 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 No Specify. White "natural", 3 X Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the BMCA (E7) US NAVY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (Fjrst, Middle, Maiden Surname) Peter Sparagna ဂ Vencenza (unk) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Peter Swartz -Nephew 30 Monroe Street Gloversville, New York 12078 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of I
Important; If it
any injury or or o Page 1 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Maryland Veterans Cemetery 12/16/2011 Crownsville, Maryland Signature of Funeral Service Licenses Bonald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, Marvland20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final disease or condition Onset and Death Physician/ CHRONIC OBSTRUCTIVE PULMONARY DISEASE Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of, 彭 or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Month Day Pregnant at time of death 5 Other (specify) detached the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? by pe 1 Yes 2 🔽 No 3 🗆 Probably 4 🗆 Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available has autopsy prior to completion of cause of death? performed? Yes 2 1 No this certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 **X**No မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at Certificate: 28d. Describe how injury occurred XNatural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital o within 24 hours af To the Funeral Di Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) moroz 2, 201 241 races GA 061688

State Registrar WRNMMC.

BETHESDA, MD 20889 5600

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

AINSWORTH

DEC 15 2011

CRAIG R

Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 08. 6:10p M December Mary Stevens Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Hebrew Home of Greater Washington Rockville If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Country) New York Marth Pay, Year 18 1 🗆 M 2 🕱 F 93 051-05-5239 Director Usual Residence of Decedent 10d. Inside City Limits ernit. Page 1 and 2 should be filed within 72 hours after death with the Maryland epartment of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any nijury or other traumatic event, the Medical Examiner must be notified at one. 10b. County 10c. City, Town or Location 10a. State Director Rockville 1 Yes 2 X No Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 20852 6121 Montrose Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. White 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Hospital Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Minnie Rubinstein Hyman Rubin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 542 Market Street East, Gaithersburg, MD 20878 Michael Stevens - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Garden of Remembrance 12/12/2011 Clarksburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 21. Signature of Funeral Service L omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part 1. Enter the dise shock, or heart failure. Lis Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examine Due to lor as a consequence of cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burist transit. that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 00 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death Certificate: (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No Natural Accider 5 Pending Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide determined Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

31. Date filed (Month, Day,

30. Name and address of person

3 29b. Signature and title of certifier

29a. Certifier

15

who completed cause of death (Item 23a) (Type, MD-

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 December 12:41pm M William Louis Stevens Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Days 1 X M 2 □ F 1918 Michigan Director 373-12-4897 Yrs Dec. 93 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland | Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11215 Seven Locks Road, #225 20854 United States ral", or items? 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: "natural", Specify: White Completed 3 X Widowed 4 □ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanical Engineering 4 Engineering Consultant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ruth Miller Nelson Stevens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4612 Woodfield Road, Bethesda, MD 20814 Kathy A. Byars (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Durial 2 Decremation 3 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 12/13/11 Alexandria, Virginia 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park 20877 21. Signature of Funeral Service License 26a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Years Pulmonary Fibrosis disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Years Asthma Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) signed by the attending physician and do be detached for use as the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Coronary Heart Disease 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed certificate has page 2 1 Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🛛 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certificate: To this ot 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After (Month, Day, Year) 1-X Natural 5 Pending Division 1 🗌 Yes 2 🗎 No Investigation 6 Could not be Accident the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Completed filled in by a 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical (x) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 06019 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day,

State Registr<u>ar</u>

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Robert Stroup 11:45pm December 10. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery General Hospital Olney Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Min. Hours **Director** 180-28-3103 1 🛛 M 2 🗆 F 81 12/28/1929 Pennsylvania Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring 1 🗆 Yes 2 🔀 No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20905 17217 Pinebrook Drive U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married X Yes 2 No 1948-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Give Completed 3 Divorced 4 Divorced 1952 White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) **5+** Educator/Coach Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Sophie Genevieve Andrews Daniel W. Stroup 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17217 Pinebrook Drive, Silver Spring, MD 20905 Barbara Stroup - Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/16/2011 Crownsville, Maryland MD Veteran's Cem. 21. Signature of Funeral Service Lice 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. <u> 1800 New Hampshire Ave., Silver Spring, MD 20904</u> complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. 23a, Part 1, Enter the diseas Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Non Traumatic Gastrointestina bleed Medical resulting in death) Due to (or as a consequence of): Examiner holana 10 if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed as the buria -trans and Due to (or as a consequence of) resulting in death) Last attending physician I for use as the buris Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month 1 Yes 2 No 9 Unknown detached the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ate has been signe page 2 should be 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) 24a. Was an autopsy performed? Yes 2 N 24 hours after death. Funeral Director; After this certificate! director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No မ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, filled in by the funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending iniury Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital c Medical To the Hosp within 24 hou To the Funer completely fi Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

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M.D. 18101 31. Date filed (Month, Day, Year) 15 2011 DEC

30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)

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V 5499 6

Prince PhilipDr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Fo AMEND#23a per PHY State of Maryland / Department of Health and Mental Hygiene 20 | | State Registrar 12/16/2011 AACO HEALTH DEPT. CMH Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2011 52AM Medical Eacility Name (if not institution **Examiner** 4b. City, Town, or Location of D County of Death **Funeral** 1 M 2 X F Jan 17 1955 New Jersey 203-44-8627 56 **Director** Usual Residence of Decedent shov 10b. County 10a. State aţ 10c. City, Town or Location 10d. Inside City Limits Director items 23a or 28a-f s ner must be notified Anne Arundel Glen Burnie Mary1and 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7967 Elvaton Rd. 21061 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 5 ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes If Yes, Give 2 X No 1 ☐ Yes 2X No Specify: "natural" Completed 3 - Widowed 4 - Divorced Specify: Black Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th 1yr Account Clerk Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Donald Forman June R. Morrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2914 Silverhill Ave Katara West(Daughter) Gwynn Oak, Md. 21207 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Metro Crematory 12-15-11 Baltimore, Md. 21. Signature of Funeral Service License Windows are are the seef Facility Sons Mortuary, Lavry 1922 Forest Dr. Annapolis, Md. 21401 23a. Part 1. Enter ty disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. terval Between Immediate Cause (Final disease or condition and Death Physician/ Multi system organ falture
Due to (or as a constituence of): Menown , Medical resulting in death) Examiner Unknow Diffuse large B Cell Lymphoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Tachycardia Unknow Due to (or as a consequence of) Physician/Medical Anemia Unknow The law requires that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Day signed by the at d be detached for Pregnant at time of death Unknown 9 Unknown P.O. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Division of Vital Records. Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an raunycardia has page 2: death? certificate anemia the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospital Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this the Funeral Director: After thin ppleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: Natural 28c. Injury at 28d. Describe how injury occurred iniury work?
1 \(\sum \) Yes 2 \(\sum \) No 5 Pending hours after death. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a To the Funeral D Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) (Q) Tidowater Coloni $\alpha(00)$ State Registrar

11-09824
Kacey Emily Shev

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State of Maryland /	Department of He	ealth and Mei	ntal Hygiene

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acey Emily Sh		State of Maryland / Department of Health and Mental In For State Certificate of Death Registrar		20 I j. No.	1 4278
Physic Medical Exam	ian/	1. Decedent's Name (First, Middle, Last) Kacey Emily Shewbridge	2. Date of Death	Day Year	3. Time of Death 1007 hrs
)	illici	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea		4c. County of Deat	L
<u> </u>		Meritus Medical Center Hagerstown 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24H	rs. 18. Date of Birth	Washington (MM/DD/YYYY) 9. Bit	thplace (State or
Funeral Director		838-83-1065 1 M 2 F F Yrs. 128 British Pays Hours M		Forei	ountryMaryland
b	1	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
nd thow an	Ļ	Maryland Washington County Hagerstown			1 X Yes 2 No
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. ten 27 is marked other than "natural", or items 23a or 28a-f sho frammatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 10f. Zip Code 638 West Washington Street 21740	100	g. Citizen of What Cou USA	ntry?
with the s 23a or	ralDi	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (14. Race - Amer	ican Indian, Black,
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ID 21215-0036 should be filed within 72 ho and Mental Hygiene. it is marked other than "na natic event, the Medical Ex) Be	Christopher Scott Shewbridge Kimber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Street ly Virgin	ia Kreis	Zip Code)	
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and N Important: If item 27 is us injury or other traumatic.	2	Christopher S. Shewbridge/Father 639 W. Washington S	t., Hager	stown, MD_	21740
Ore, es land of Heal If item		20a. Method of Disposition 1 Burial 2 XXCremation 3 Removal from State crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City of	`
Baltimore, permit. Pages I an Department of He (mportant: If ite		4 Donation 5 Other Specify: Smithsburg Crematory Jan 21: Signature of Funeral Service Licensee , 22. Name and Address of Facility Do	ouglas A.	Fierv Fun	g, MD eral Home
Balti permit. Departri Imports		1331 Eastern Blvd	N. Hage	rstown, MD	21742
Physician Trineurca		23a. Part I. Enter the disease or combications that caused the death. Do not enter the mode of dying, such as cardiac failure, List only one cause on each line. Immediate Cause (Final disease a. Sudden Unexplianed Death In Infancy	or respiratory arres	st, snock, or neart	Approximate Interval Between Onset and Death
Examine		Immediate Cause (Final disease or condition resulting in death) a. Sudden UnexpII and Death In Intancy Due to (or as a consequence of):			
	Je.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last			
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'60, ate be e ohysicia	Medi	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delive	у
Box 68760, e death certificate buthe attending physic ed for use as the buthe	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)	nancy	Month	Day Year
. BOy he death y the att hed for	hysi	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e Did tob	pacco use contribute to	the cause of death?
Records, P.O. Box 68760 The law requires that the death certificate teate has been signed by the attending physispace 2 should be detached for use as the buy	2	Part II. Other significant conditions		_	bably 4 好 Uriknown
of Vital Records, ng Physician: The law required the this certificate has been sineral director, page 2 should be	Completed		24a. Was er autops	y prior to	utopsy findings available completion of cause of
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Of Vital 18 Physician: ther this certifineral director,	m	25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Cher		Residence 6 Othe	er:
_ = = . ` ≪	-	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe ho	ow injury occurred	
Division spital or Attenditions after death.	ficati	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.			ural Route Number, Gity Shington St.
Divi	Certification	4 Homicide determined (Specify) Residence	Hagerst	own,MD.	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a control one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and manager stated.	nd due to the cause d at the time, date a	e(s) and manner as sta and place, and due to t	ted. he cause(s)
To wit	Me	29b. Signature and title of certifier 29c. License number		29d Date signed (M	
		30. Name and address of person who completed cause of death (Item 23a)		December 31, 2	
		Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore,	MD 21223		
Regi	State strar	31. Date filed (Month, Day, Year) 2012 32. Registrar's Signature & Sansar			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Nannie Lee Bridegroom Steenken 2011 10:32 Λ DEC Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Caroline 23804 Grove Road Preston Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 Director 252-20-3906 90 1921 15 Georgia Sept Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director Preston Caroline MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21655 23804 Grove Road United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married 2 XNo Yes Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 😾 No Specify: Specify: White 3 ₩ Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Poultry Line Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Lee McDonald Fannie Mae Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elwood W. Bridegroom/Son 23804 Grove Road, Preston, MD 21655 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Preston, Maryland 12/23/11 Junior Order Cem. 22. Name and Address of Facility Framptom Funeral Home, 21. Signature of Funeral Service Licensee uhael 4 skew 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final 30000ple Physician/ cosonary disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exam Cause (Disease or linjury the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death 5 Other (specify) Unknown 9 Unknown signed by ti P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ emention Division of Vital Records, adranced 1 Yes 2 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has I funeral director, page 2 s autopsy Hospital or Attending Physician: The Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home Residence 6 Other (Specify, Hospital 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No hours after death. Accident
Suicide
Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 🗫 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Signa re and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

Wellinga

31. Date filed (Month, Day, Year) 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Butter

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D0053255

3683 Chapterk R2 Preston ND 21685

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 29d per phys. g923 1-26-12 vt
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 13, 20⁴11 Donald Carlo Tessitori 3:59 рΜ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Silver Spring 4c. County of Death Montgomery Examiner Holy Cross Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year, 201-22-9553 1 MM 2 □ F Director 80 Feb. 20, 1931 NY Usual Residence of Decedent or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Montgomery Rockville MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20853 12809 Caldwell Street 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White Year or Dates. 1950-54 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. other than " College (1-4 or 5+) Elementary/Secondary (0-12) Flooring Sales Estimator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fisher is marked o Antionette Maxillion ပ Paul H. Tessitori 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 12809 Caldwell Street, Rockville, MD 20853 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Rose Tessitori/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Jan. 25 2012 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State Arlington National Cemetery Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiopulmonary Arrest disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Metabolic Acidosis Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Pand Transit The law requires that the death certificate be executed Small Bowel Obstruction that initiated events resulting in death) Last Due to (or as a consequence of) nding physician a use as the burial-Physician/Medical Bladder Cancer Box 68760 use as 1 If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant ρď in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav ed by the a detached f P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b director, page 2 s autopsy performed? Yes 2X No of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 1x No ၀ 4 Nursing Home 5 Residence 6 Other (Specify) 1x Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of injury 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending Division 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Pragritioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year)
Dec. 13, 2011 29b. Signature and title of certif Dec. D65069 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road, Silver Spring, MD 1500 Forest Glen Road, Silver Spring, MD 20910 31. Date filed (Month, Day, Year) **DEC 16** 2011 32 Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician Year 9:30 PM 12 26 <u>Virginia Elizabeth TROVINGER</u> 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington Ravenwood Lutheran Village Hagerstown Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthdav) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 💢 F Director 215-14-2889 91 July 15 1920 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show Department of Health and Mental Hygiene, important; or Items 23a or 28a-f show important; if item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the "Nedical Examinat must be cotified at once. 1 ☐Yes 21 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19800 Tranquility Circle #205 Funeral 21742 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Credit Dept. Retail Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Warren C. Charles Clara Louise Ridenour 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Terry Trovinger - Nephew</u> 18820 Rolling Road, Hagerstown, Maryland 21742 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 12/29/2011 | Hagerstown, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Alterochore Cardio voscular MINIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to ministrate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a someoquenea of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year signed by the a t be detached f 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should I 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate performe 2 🗷 No 1 ☐ Yes 2 🗷 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 ☐ Accident within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 31. Date filed (Monti State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** ERNESHINE STANSIMORE /Medical 4c. County of Death 4b. City, Town or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** CHARIES HERITI CARE 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days 230-62-9167 1 □ M 2 🖼 64 126-INIA Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 des 2 No Director TRINCE 10g. Citizen of What Country? 10e. Street and Number KOTINE ZACE Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working yee. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) ConfuTeis HNAL 1/515 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ERNEST SHANKS P 19b. Mailing Address (Street and Number on Rural Route Number, City or Town, State, Zip Code) 2073.5 1535 Chilm B 20c, Location - City or Town, State 7 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/20/11 Va LIGNUM 4 □ Donation 5 □ Other (Specify) Thompson Ferraco Horse 21. Signature of Funeral Service Licensee Ul PEDER. Da omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest nly one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease of shock, or heart failure. List Preumonia Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical montas Examiner Sequentially list conditions, if any leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending pl IF FEMALE: If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by encephalo damage 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of dysplagia 24a. Was an death? perform 2 No 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2☐ Yo 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 D Natural 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 1 Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

State DEC 2 Registrar

R. Smoller en

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

D6061614

12/22/11 JINDHWAN !

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Office Rd., Waldorf

31. Date filed (Month, Day, Year) 32. Registrar's Signatur 7 2011

P.O. Records, Vital

Division of

law requires that the death certificate be executed Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: A completely filled in by the fi

Physician

/Medical

Examiner

Director

Funeral

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Physician/Medical Examiner

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Be

Medical Certification: To

Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Monteel Examination in the north of ponee.

Physician

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Examiner

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cate has been signed by the a page 2 should be detached

funeral director,

After this

Maryland 21215-0036

Baltimore,

BA 5

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATESAN DR-USHA 31. Date filed (Month, Day, Year)

29a. Certifier

(Check only one)

29b. Signature and title of certifier

ushaNah

and manner stated.

1415-5-DIVISION 32. Registrar's Signature

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

57

29c. License number

0051359

SALESBURY

29d. Date signed (Month, Day, Year)

December

21804

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 8:00 Gary Richard Taylor, Sr. December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death aurel Regional Prince George's -aure Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 219-46-2327 1 🕅 M 2 □ F Hours Aphr. 28 , 1947 64 Maryland **Director** ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits Funeral Director Maryland Prince George's 1 X Yes 2 □ No Laurel 10f. Zip Code 10g. Citizen of What Country? 8519 Locust Grove Drive 20707 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Force 1 ☐ Yes 2 🔀 No If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Drywall Engineer KenMar Drywall, Inc. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lawrence Dana Taylor Margaret Louise Gauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 16900 Melbourne Drive Laurel, Maryland 20707 Kenneth Lawrence Taylor - brother 20a. Method of Disposition
1 ☐ Burial 2 ⚠ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Metropolitan Crematory 12/21/2011 Alexandria, Virginia 21. Signature of Funeral Service Licenses Bonalad V: Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland20705 Monald 23a. Part 1. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Respirator disease or condition resulting in death) mins Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and that initiated events resulting in death) Last attending physician and for use as the burial tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? signed by the at d be detached for Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes Mellitus, Hypertension, 1 Yes 2 No 3 Probably 4 Unknown page 2 should Hypercholesterolemia, Advanced Kidney Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 🗙 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 X No Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation the 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined Medical XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practigner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier December 13, 2011 D 16605 7300 Van Dusen Rodd 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wang Koon, M.D Laurel Regional Hospita Emergency

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1- Registrar Cer	rtment of Health and M tificate of Death	Reg. No. 20	11 4279					
Physic /Medi		1. Decedent's Name (First, Middle, Last) Dor'S Tham? 5		2. Date of Death Month Day Yea	9:40 BW					
Examin Funeral		4a. Facility Name (If not institution, give street and number) Part Cale Chuy Chuy 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 10 M 2 F	4b. City, Town, or Location of Death A City Chast If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	Month, Dav. Year)						
Director show ed et	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local 10c. City, Town or		11/4/1926	10d. Inside City Limits 1 X Yes 2 □ No					
with the N a or 28a-f be notifia	Director	MD Montgomery Chevy Chas 10e. Street and Number 8700 Jones Mill Rd.	10f. Zip Code 20815	10g. Citizen of What	Country?					
IN LINE 19-0030 filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ant, the Medical Examiner must be notified et	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Very 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Nas Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto t ☐ Yes 2 kg No Specify:	Specify:	merican Indian, Ihite, etc. White					
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and Zi	Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maiden Surname) Dan Fanning	VICE					
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DEMITTING permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licensee 22.	2. Name and Address of Facility St 46 N. Washington	nowden Funeral Ho St., Rockville, M	me, P.A. D 20850					
ate be executed This control is a control in the purish the puris	ical Examiner									
Hecords, P.O. Box b8/bu, The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the bunaturansit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ MO 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 € 4 □ Pregnant at time of death 5 € 9 □ Unknown	□Ectopic pregnancy □ Other (specify)	23d. Date of Month	f delivery Day Year					
dS, F.	þ	1 at a 1 possue had and	underlying cause given in Part I.	23e. Did tobacco use contribu	te to the cause of death? ☐ Probably 4 ☐Unknow					
al Kecords, The law requires the cate has been signe, page 2 should be c	Completed	Congestive Least Failnes de mentia		autopsy pno dea 1 Yes 2 ☑ No 1 ☐	re autopsy findings availabler to completion of cause of th? Yes 2 No					
Or VITal Physician: 7 r this certificat	To Be	1 Yes 2 No	ent 3 DOA Other: 4 Nursing I	ath (Check only one) Home 5 ☐ Residence 6 ☐ Other (28d. Describe how injury occurred	(Specify)					
DIVISION OF VITAI HE To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page?	Certification:	27. Manner of Death Natural 5	Work? M 1 ☐ Yes 2 ☐ No	28f. Location (Street and Number of City or Town, State)	or Rural Route Number,					
Hospital (Hospital (Hospital (Funeral D tely filled ii	Medical Cer		ath occurred at the time, date and place investigation, in my opinion, death occ	ee, and due to the cause(s) and mann curred at the time, date and place, and	er as stated. d due to the cause(s)					
To the within 2 To the To the	Med	from the -wo	000000	29d. Date signed ()	Month, Day, Year)					
9	State	30. Name and address of person who completed cause of death (Item 23a) (Type Summit Gupt 9 - 570V Jone 31. Date filed (Month, Day, Year) 32 Registrar's Signature	5 mill Road	, Chry Chusa, My	1 2 0 1					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 Year Physician/ PM 230 G Umaña 2011 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Medical **Examiner** Of MARYZAHD Baltimone, 0814G If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Hours 215-06-4505 Cojutepeque, 1 🗆 M 2 🕱 F **Director** 68 April 7, 1943 <u>Salvador</u> 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State notified at Director 1 X Yes 2 No Maryland Greenbelt Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò er than "natural", or items 23a of the Medical Examiner must be Funeral 20770 El Salvador 6213 Spring Hill Court Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc 1 Never Married 2 X Married Yes 2 X No þ Maryland 21215-0036 1 X Yes 2 ☐ No Specify: If Yes, Give Year or Dates Salvadorian Specify: Hispanic 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation Je filed wn. ≺tal Hygiene. 'Ser than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even ည Ofelia Chico Raul Rodriguez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6213 Spring Hill Court, Greenbelt, MD 20770 Tulio E. Umana / Husband altimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 12/27/2011 Fort Lincoln Cemetery Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licensee 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 RAY Royers 23a. Part 1. Enter the decase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Mucinous metastatic disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to mini solute cause. Enter Underlying Examiner Due to for as a nonsequence offy attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy or Attending Physician: The law requires that the death in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year Day 5 Other (specify) Pregnant at time of death signed by the at d be detached fo Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Division of Vital Records, been si should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed?
1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After work? 1 ☐ Yes 2 ☐ No 1 Natural injury 5 Pending Investigation Accident filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1671892240 December 23, 2011

State Registrar 30. Name and address of pe

31. Date filed (Month, Day, Year)

Brittney Williams

son who completed

Greene

St. Baltimore

MD

21201

ause of death (Item 23a) (Type, Print)

Bookh

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0202 201 December Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** Hmore None 9. Birthplace (State or Foreign Age (In yrs. last birthday) 8. Date of Birth **Funeral** 142 34 3791 Director 1 X M 2 🗆 F 66 June 19, 1945 New York Usual Residence of Deced 28a-f show 10a. State ms 23a or 28a-f shorens or must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8918 Mt. Patapsco Court 21042 United States items death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 1 X Yes 2 No
If Yes, Give
Year or Dates. 1967-77 9 by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify "natural", Completed 3 Widowed 4 Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) n and Mental Hygiene.
7 is marked other than "i Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Manufacturing Attorney traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frank C. Vissers Elsa Bertha Lagast 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 permit. Page 1 and 2 Emily Vissers/Wife 8918 Mt. Patapsco Court Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 Cremation 3 X Removal from State West Point Cemetery | 6-19-2012 4 Donation 5 Other (Specify) West Point, NY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Bacterenco disease or condition resulting in death) enterococca) Medical Examiner Abscess Sequentially list conditions. Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Pancreatic conve vate has been signed by the a ending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Physician/Medical certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Dav Year g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe certificate 1 Tes Division of Vital To the Hospital or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: 1 Yes ည 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death Certificate: 28a. Date of injun 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

Rebecca 31. Date filed (Month, Day, Year)

DEC 20

600 N. Wolfe St. Baltimore MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Stella Ventriglio ам December 2011 10:37 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months Days Hours Min (Month, Day, Year) 053-01-4726 **Director** 1 M 2 XF Yrs Sept. 30, 1914 Italy Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 🗌 Yes 2 🔀 No MD <u>Montgomery</u> Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a 11621 New Hampshire Ave., 20904 death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc 0 by 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates. Page 1 and 2 should be filed within 72 hours after Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: "natural" Completed 3 Widowed 4 Divorced of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Dress Designer/Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Luigi Bonanno Concetta Costello 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Ventriglio/Son 2009 Wooded Way, Adelphi, MD 20783 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Dec. Date 17, Department of H Important: If ite any injury or ot once. 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) John's Cemetery Middle Village, NY 2011 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, 21. Signature of Funeral Service Licenses MD 20901 nt 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Bilateral Pneumonia Days Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and der use as the buriations. Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) in the past 12 months?

1 Yes 2 X No Month Dav Year detached the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Renal Failure, Hyperkalemia, Systolic Dysfunction, Division of Vital Records, 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? COPD, Hypertension 24a. Was an autopsy r this certificate has be aral director, page 2 s perform Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 X No 1 🖾 Inpatient 2 🗆 ER/Outpatient 3 🗀 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🎦 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatore and tittle of certifier Swamsin D53367 Dec. 10, 2011 me and address of person who completed cause of death (Item 23a) (Type, Print)
nyamsundar Rajan, MD 9801 Georgia Avenue, #117, Silver Spring, MD 20902 Shyamsundar Rajan, MD

Registrar

State

31. Date filed (Month, Day, Year)

Registrar's Signatu

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	Funeral		GENESIS LA PLAT 5. Social Security Number 6. Sex		e (In yrs. Ia:	st birthday)		er 1 Year	If Under 24 Hrs. Hours Min.					place (State or Foreign		
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36	after d I", or i camin	ě	1 ☐ Never Married 2 XXMarried 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🔀 If Yes, Give	No	- 1			Specify:	o Rican, etc.)			ck, White, " WH]			
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Maryland	should and Ma is mar aumati		19a. Informant's Name/Relationship (Type	e, Print)		19b. Mailir	ng Addre	ss (Street a	and Number or Ru	ral Route Numbe	r, City or	Town, S	State, Zip (Code)		
	and 2 Health em 27 ther tr		DONALD E. RATLI 20a. Method of Disposition	FF/HUSB	_	4635			RDTOWN I					20601 own, State		
nor			1 ☐ Burial 2 ★ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	CE	emetery, cren 'RO • CF	natory`or	other place	jan.	Date 7 . 2012				RIA, VA		
Baltimore,	permit. Page Department of Important: If any injury or once.	- 1	21. Signature of Funeral Service Licensee	CO										CE,P.A.		
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Box 68760	ath ce attenc I for us	Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live Birth 4 Pregnant a	2 🗀 Fetal	Ideath 3 □	Ectopic Other	pregnanc specify)	Э				ate of deliv onth	ery Day Year		
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Z Z	Physic this ce al dire	၉	1 ☐ Yes 2 ☑ No Ho 27. Manner of Death	ospital: 1 Inpati		ER/Outpatier 28b. Time of		_	4 Nursing F	lome 5 Resid)		
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á	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death certificate besidning the surface of the this certificate has been signed by the attending physici to the Euneral Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director.															
	e Hosp 124 ho e Fune eleted f	Medical	29a. Certifier 1 Certifying Physic (Check 2 Medical Examine only one) 3 Certifying Nurse	er: On the basis of e	xamination	and/or invest	tigation, i	n my opinio	on, death occurred	at the time, date a	and place,	, and du	ie to the ca	use(s) and manner stated.		
	To the vithin To the comp	2	29b. Signature and title of certifier	I	Door or my	Milotiloago, t		c. License					d (Month,			
			Juanneap	bue				DO	70900)		2 2	27/1			
	5		30. Name and widdress of person who cor	mpleted cause of d	eath (Item	23a) (Type, F	Print)	in	1A A	200000	lie	M	D	21401		
	Stat	e	31. Date filed (Month, Day, Year)	32. Registra	ar's Signati	ure		UIN		1110/20	1117	11.	1/	- 1 1 0 1		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1^{Month} 14^{Day} 201^{rea} 12:50AM Daniel Lafie Wolfe Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Golden Living Center Frederick Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 3/14/1905 Director 214-10-2985 106 1 ★ M 2 □ F er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Frederick Myersville 1 Yes 2 No 10f. Zip Code 21773 10e. Street and Number 10g. Citizen of What Country? Funeral 9916 Harmony Rd. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry and Mental Hygiene. life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) door co. carpente Be 17. Father's Name (First, Middle, Last)
Albert C. Wolfe 18. Mother's Name (First, Middle, Maiden Surname)
Ida Winfield မ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roland Wolfe (Son) 6442 S. Clifton Rd., Frederick, MD 21703 20a. Method of Dis 20h. Place of Disposition (Name of Hoemers) Crambotor Corbinator (Name of Place) O 20c. Location - City or Town, State Cremation 3 Removal from State Brethren Cemetery 5 Other (Spec 12/19/11 Myersville, MD ²² Name and Address of Facility
Donald B. Thompson Funeral Home plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one sause on each line. Part 1. Enter the disease, or complice spock, or heart failure, List or y one Approximate Onset and Death Immediate Cause (Final **Physician** X LETWIS 15 STUNKE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death signed by the at d be detached for Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perforn 2 No 1 Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other 1 Tes ၉ 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 IDOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident work? 1 🗌 Yes 2 🗌 No iniury 5 Pending within 24 hours after death.

To the Funeral Director: All completely filled in by the fu Investigation filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month

814 TOIL HOUSE

Ave TheDEruck

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

KAZMI

HM

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	Otato of Maryian	Cen	tificate of D	eath	Reg.	No.				
	Physicia	n/	1. Decedent's Name (First, Middle, Las	t)				2. Date of Death Month	Day Year 15, 2011	3. Time of Death			
	Medic	al	DOROTHY JEAN WILD 4a. Facility Name (if not institution, give			4b. City, Town, or L			15, 2011 4c. County of Death	7:30 A M			
	Examin	er		RON POINT RETIREMENT FACILITY CHESTERTOWN KENT									
Ī	Funeral Director		5. Social Security Number 6. Si 146-26-7298			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea OCTOBER	9. Birtl 28 , 1922	nplace (State or Foreign Intry)			
	ind show at	'n	Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Loc	ation	-	<u> </u>		10d. Inside City Limits			
	Maryla 28a-f s stified	rect	MARYLAND KENT	CHE	STERTO	WN				1x Yes 2 □ No			
	h the	Funeral Director	10e. Street and Number			10f. Zip Code		ľ	10g. Citizen of What Country?				
	ath wil	nner	117 HERON POIN	T 12. Was Decedent Ever in U.S	S. 13. W	21620	panic Origin? (Speci		or No- 14. Race - American Indian,				
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 █️No If Yes, Give Year or Dates.		Yes, specify Cuban ☐ Yes 2 ☐ XNo	panic Origin? (Speci , Mexican, Puerto Ri Specify:	ican, etc.)	Black, White	, etc.			
2-0	72 hou "natu edica	Completed	15. Decedent's E (Specify only highest gr		(Give k		tion Iring most of working	g 16t	. Kind of Business I	ndustry			
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b	be filed v ental Hyg rked othe ic event,		17. Father's Name (First, Middle, Last)				18. Mother's Name		en Surname)				
<u>≯</u> a	should be file and Mental I 7 is marked o raumatic eve	욘	EVERETT ELMER WI				ZELLA HIC						
, Mai	and 2 shor Health and tem 27 is n		19a. Informant's Name/Relationship (7 KENNETH LEE WHIT	E/ SON	9837	WHETSTONE	DR • MONT	EGOMERY		ARYLAND 20886			
Baltimore, Maryland	Page 1 а nent of H ant: If ite ury or oth		20a. Method of Disposition 1 ☐ X urial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci.	Removal from State	emetery, crem	sition (Name of natory or other place			E. Location - City or THESTERTOW	Town, State N, MARYLAND			
Balti	permit. Page 1 Department of Important: If ii any injury or o		21. Signature of Funeral Service Licent							HOME. P.A. 21620			
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only of	plications that caused the deatl						Approximate Interval Between			
_	nysician	ì	Immediate Cause (Final disease or condition	PARKINSO	N5	DISEASE	=			Onset and Death			
	Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):	-71-				3			
		ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequ	uence of):					_			
	uted	Examiner	Cause. Enter Underlying Cause (Disease or iinjury that initiated events	C									
	e exec cian ar urial-tı		resulting in death) Last	Due to (or as a consequ	uence of):								
8760	cate by physic the b	Medical		l d					_				
Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 Live Birth 2 Feta 4 Pregnant at time of c	,		23d. Date of del Month	ivery Day Year					
s, P.O.	requires that the der been signed by the should be detached	by	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	nderlying cause give	en in Part I.		. /	the cause of death?			
Division of Vital Records,	sician: The law requi s certificate has been lirector, page 2 shoule	Completed						24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of			
<u>e</u>	ian: T artifica ctor, p	Be C	25. Was case referred to medical examiner?	W			ce of Death (Check		NO TE ICO	2,110			
₹	Physic this ce al dire	은	1 ☐ Yes 2 No	Hospital:	ER/Outpatien		4 Nursing Hon		6 Other (Spec	ify)			
<u>0</u>	ding F th. After funer	cate	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigatio	28a. Date of injury (Month, Day, Year)	injury	28c. Injury work? M 1 🗆 \	et Yes 2 \(\subseteq No	8d. Describe how in	njury occurred				
ivisio	or Atten after deaf Director: in by the	Certificate:	2 Accident Investigatio 3 Suicide 6 Could not b 4 Homicide determined	De 280 Place of Injuny - At ho				8f. Location (Street City or Town, St	and Number or Rui ate)	ral Route Number,			
Ω	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page	Medical	(Check 2 Medical Exam	rsician: To the best of my knowl niner: On the basis of examination	n and/or invest	igation, in my opinior	n, death occurred at t	the time, date and p	ace, and due to the	cause(s) and manner stated.			
	o the vithin 3 comple	Ž	only one) 3 L Certifying Nur 29b. Signature and title of certifier	se Practioner: To the best of my	y knowledge, c	leath occurred at the 29c. License			Date signed (Month				
9	15		> Hunk	Mble			041587		12 15	2011			
	MS		30. Name and address of person who	122 Speci	Rac	id the	STEPTON	N. MI	2162	20.			
	Sta Registr		31. Date filed (Month, Pay Year)	32. Registrar's Signar	iture A.	parte							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended 2 & 1 = For State Regis State Registrar 4a, 12/20/11, ram, Kent Co Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 11 3. Time of Death Day Month Physician/ magne Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 900 0 Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Hours Min. Day, 217-12-4201 MD Director Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location Chestertown 10a. State 10b. County 10d. Inside City Limits death with the Maryland Director Queen Annes MD 1 🗌 Yes 2 🔀 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö iral", or items 23a or Examiner must be 21620 1216 Ewingtown Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian 11. Marital Status Black, White, etc 1 Never Married 2 Married þ Specify: Black Maryland 21215-0036 72 hours after 1 Yes 2X No Specify: If Yes, Give "natural", 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Ith and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med within 7 Elementary/Seconday (0-12) College (1-4 or 5+) Vita Foods Laborer 06 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Merital I Important; If item 27 is marked o any injury or other traumatic eve Saunders Belle Anderson Hannah ျ Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1216 Ewingtown RD Chestertown, MD 21620 Erma Wright/Daughter Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other o ch. Neck Hall Cemetery 1 Burial 2 Cremation 3 Removal from State 12/23/2011 Chestertown, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Bennie Smith Funeral Home 21620 Chestertown, MD 855 High ST 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Ce rebroyasu disease or condition Medical resulting in death) Due to (or as a consequence of Examiner MIL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examin Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and 2 heiners and -tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant Pregnant at time of death isigned by the a Yes 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown noity of tena Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy performed?

☐ Yes 2 No 2 🖃 No 1 🗌 Yes 26. Place of Death (Check only one) Division of Vital 25. Was case referred to medical funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ည 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 Inpatient 2 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of 2 D00 E person who completed cause of death (Item 23a) (Type, Print) IN Ni Rm 216 State Registrar

11-09719 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. David Earl Wolf, Jr. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Medical Examiner** David Earl WOLF, Jr. December 23, 2011 1733 hrs 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Meritus Medical Center Washington Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director 214-09-0160 1X M 2 F 94 Country) Maryland Dec. 29,1916 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits 28a-f show 1 XYes 2 No Maryland "natural", or items 23a or 28a-f sho Examiner must be notified at once. Washington Hagerstown and 2 should be filed within 72 hours after death with the Maryland Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1178 Cottage Court 21740 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married White, etc. 1 X Yes 2 other than "natural", or 4 Divorced If Yes, Give Year 1943-46 3X Widowed 1 Yes 2 X No specify: white \$ 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry pleted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 insurance 12 1 agent and broker and Mental Hygiene. Com 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Lillian Irene English David Earl Wolf. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David A. Wolf - son 13306 Unger Rd., Hagerstown, Maryland 21742 of Health item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place? Burial 2 XCremation 3 Removal from State 12/28/11 Hagerstown Crematory Hagerstown, Maryland Donation 5 Other Specify 21. Signature of Funeral Ser 22. Name and Address of Facility MINNICH FUNERAL HOME E. Wilson Blvd., Hagerstown, Md. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval Between Onset and /Medical Death a Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease **xaminer** or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transi sician/Medical UNPENDED attending physician or use as the burial -AMENDED Division of Vital Records, P.O. Box 68760, IE EEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Month Year past 12 months? Pregnant at time of Other (Specify) 1 Yes 2 No 9 Unknown death Unknown 9 Phy the detached 1 Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Neck Injury, Chronic Obstructive Pulmonary Disease, Acute Renal Failure 1 Yes 2 No 3 Probably 4 V Unknown peen 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed death? Com page Yes 2 V No 25. Was case referred to medical 26.Place of Death (Check only one) To the Hospital or Attending Physician: Be Hospital: 1 / Inpatient 2 Other Nursing Home 5 Residence 6 Other ER/Outpatient 3 1 🗸 Yes 28a. Date of Injury (Month. Day Year) Dec 22, 2011 After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Subject fell out of his wheelchair Natural 1930 hrs 5 Pending 1 Yes 2 ✔ No 24 hours after death 2 🗸 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Suicide 6 Could not be or Town, State) 1183 Luther Drive, Hagerstown, MD (Specify) Assisted Living Facility Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the 1 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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State
Registrar

DHMH 17 Rev 1/2001

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Ling Li, MD As

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

O.C.M.E.

December 27, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ R16 141 1:43 RANCES December 2011 A^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex **Funeral** 221-10-1105 Director 1 🗆 M 2 🕱 F 90 Yrs December 23,1920 Pennsylvania Usual Residence of Decedent ms 23a or 28a-f show must be notified at within 72 hours after death with the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Anne Arundel Davidsonville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21035 2410 Fox Creek Lane Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status ral", or iten Examiner i Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 XNo 1 Yes 2 X No Specify Specify: White 'natural", 3 X Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the 12 Hairdresser Salon Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ပ္ Mabel Gertrude Jackson Jessie James Buckalew and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2410 Fox Creek Lane, Davidsonville, Maryland 21035 Susan W. Mongeau / Daughter other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Burial 2 X Cremation 3 Removal from State 12-16-2011 | Edgewater, Maryland Kalas Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home Signature of Funeral 2973 Solomons Island Rd., Edgewater, MD 21037 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, specific repeat failure. List only one cause on each line. Approximate Interval Between Onset and Death heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ maumonia DA-45 Medical Due to (or as a consequence of) resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical certificate be IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ✔No Month Day Year Pregnant at time of death 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗫 nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy The law has performe 1 Yes 2 No Yes 2 N To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 **N**o Other: Certificate; To 1 Inpatient 2 ER/Outpatient 3 E 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred eral Director; After filled in by the funer 1 Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Maryland 21215-0036

Baltimore,

68760

Box

P.O.

of Vital Records,

Division

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

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Physicia Medio		John	Howa	rd Wise	man, Sr					Decemb	er 1	^{ay} 13, 2	Year 2011	12:4	5 P M
Examin	er			, give street and nur	·		4b. City, Town, o			c. County					
Funeral		5. Social Security N	umber	Sedical Ce	7. Age (In yrs.	last birthday)	Annapo If Under 1 Year Months Days	8. Date of Bir				hplace (State intry)	or Foreign		
Director		219-28-5 Usual Residence of		1 X M 2 □ F	Working Days	Hours	Min.	May 13		31		yland			
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or 28a- notifie	Direc	10e. Street and Nun		Arunder		everna	10f. Zip Code		1 □ Yes 2 □						es 2 XNo
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director			Annapoli	s Blvd.	•	2114		-	JSA	viiat oo	unid y :			
r death or item uiner n		11. Marital Status 1 □ Never Marr	iod 2 WMar	Armed Fo	edent Ever in U. orces? Kor 2 \(\text{No} \)	s. rean	Was Decedent of H f Yes, specify Cuba	ispanic Origin an, Mexican, F	n? (Spe Puerto	ecify Yes or No- Rican, etc.)			e - Amer k, White	ican Indian, , etc.	
ural", o	Completed by	3 Widowed		If Van Cit	/e V	Var	1 ☐ Yes 2 🌠 No	Specify:				Specify:		White	
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To the within 2 To the comple	Ž	only one) 3 29b. Signature and		Nurse Practitione	To the best of	my knowledge,	death occurred at t		and pla	ice, and due to				stated. , Day, Year)	
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician/edical Examiner 1. Decedent's Name (First, Middle, Last) Howard Alan Walker 4a. Facility Name (if not institution, give street end number) Calvert Memorial Hospital 5. Social Security Number Calvert Number Calvert Number 6. Sex 7. Age (In yrs. last birthday) Usual Residence of Decedent 7. Age (In yrs. last birthday) Usual Residence of Decedent 2. Date of Death Nonth Day Pear December 19, 2011 4c. County of Death Calvert 4c. County of Death Calvert 4c. County of Death Calvert 4c. County of Death Calvert 4c. County of Death Calvert 4c. County of Death Calvert 1	walu vvaikei		State of Maryland / - For State degistrar		ate of Death	nemai my	Reg	No. 201	1 4280			
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Bonnie N. Walker Wife 12605 Catalina Drive, Lusby, MD 20657 Summary 200	Z = E E	Be	Charles L. Walker	Berg								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Z011 Physician/ 2327 Waters-ARBARA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Feb. 20, 1940 Days 213-40-8183 1 🗆 M 2 🗷 F 71 D.C. **Director** Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10d. Inside City Limits 10a State 10c. City. Town or Location Director MD Anne Arundel Lothian 1 Ves 2 No 10g. Citizen of What Country? 10f. Zip Code 20711 Street and Number 5239 Sands Road Funeral items Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Examiner Armed Forces? Black, White, etc. or 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 🛣 No Specify: th and Mental Hygiene. 27 is marked other than "natural", traumatic event, the Medical Exan If Yes, Give Year or Dates 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)

Teacher (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Public Schools 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Thomas Freeman Samue1 Pear1 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1790 Parkers Creek Rd. Port Republic, MD20676 TaWanda Waters/daughter item 27 20a. Method of Disposition
3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Department of Important: If it any injury or o once, Moses Cemetery 12/22/11 Lothian. MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sewell Funeral 1451 Dares Beach Rd. Prince Home:, MD20678 Glady a 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ ENAL disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** EARS Sequentially list conditions, if any, leading continuous cause. Enter Underlying Cause (Disease or injury Examiner The 1 for its a in misculance of attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Year Day the detached Unknown ρ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by NDROME Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown ONGESTIVE HEART FAILUNG Were autopsy findings available prior to completion of cause of 24a. Was an ate has t autopsy death? 1 Yes 2 No this certificate ☐ Yes eral Director; After this certific filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1-Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital o within 24 hours af To the Funeral Di completely filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) le cember W eted dause of d Name and address of person who comp ICHAEL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

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Birthplace (State or Foreign Country)

10d. Inside City Limits

Onset and Death

1
▼ Yes 2 □ No

MD

Black

Month

Day

2 No

Registrar DHMH 17 Rev 06-2011

State

NILANTHA

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Physician Month Year /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Shady Grove Genesis Health Center Rockville If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** 2**X** F 1 □ M MD 86 579-26-9570 12/10/1924 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ral", or Items 23a or 28a-f shov Examiner must be notified at 1 XYes 2 No Director Silver Spring MDMontgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20910 USA 10000 Brunswick Avenue, #606 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: ģ Black 3 ☐ Widowed 4 Divorced 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical Mental Hygiene. arked other than Elementary/Secondary (0-12) College (1-4or 5+) Home 12th Domestic Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental 7 is marked o Harriet Rebecca Swailes Samuel Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3724 Manor Road, Chevy Chase, MD 20815 Department of Health a Important: If Item 27 is any Injury or other trainonce. Michele Williams/granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 12/27/2011 Rockville, MD 5 Other (Specify) Parkkawn Mem. Park 4 Donation 22. Name and Address of Facility Snowden Funeral Home 21. Signature of Funeral Service License 246 N. Washington St, Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 1cumor 191 /Medical as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, buria physician for use as the IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown ate has been signed I page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to Division or Vital Records, þ 1500 1 ☐ Yes 2 TNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Wère autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an autopsy perform 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1, Natural 2 ☐ Accident 5 ☐ Pending investigation 1 Tyes within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 06062435 29d. Date signed (Month, Day, Year) 29b. Signature and title of co

State Registrar 30. Name and address of person with

Year)

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1. Decedent's Name (First, Middle, Last) Physician WILLIAms /Medical Eacility Name (If not institution, give street and number) **Examiner** 110m 0 lursing TOMHE Social Security Number 7. Age (In yis. last birthday) **Funeral** Months Days 1 □ M 2 🖺 F 68 Yrs **Director** 292-40-0012 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 27 is marked other than "natural", or Items 22. ----10b. County 10c. City, Town or Location 10a. State Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 20850 1235 Potomac Valley Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 If Yes, Give 2 X No 1 ☐ Yes 2X No Š 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Elementary/Secondary (0-12) 12 College (1-4or 5+) unknown 17. Father's Name (First, Middle, Last) Be ဝ unknown 19a. Informant's Name/Relationship (Type. Print) Aida McCann, Custodian 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee MO1102 201 Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Single Infally list canditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760 attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð Completed Be 25. Was case referred to medical examiner? Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide determined 4 Homicide

11 2011 December 4c. County of Death 4b. City, Town, or Location of Death loutaane EUIII If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State of Foreign Country) Year 27 1943 Maryland July 10d. Inside City Limits 1 ☐ Yes 2 No 10g. Citizen of What Country? United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: Caucasian 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) unknown 18. Mother's Name (First, Middle, Maiden Surname) unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1235 Potomac Valley Road, Rockville, Maryland 20850 20c. Location - City or Town, State Date Ft. Lincoln Crematory 12/27/2011 Brentwood, Maryland 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 □ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier 1 🗆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) unserting the manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Molecular Drive maryland 2085 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARY Haynos 10110 MULE 32. Registrar's Signature 31. Date filed (Month, Day, Year) 5 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

Day

Registrar DHMH 17 Rev 1/2001

Medical

State

completely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 26,2011 5:00A Dec Naomi Κ. Winesett /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Whiteford Harford 2140 Linebridge Road | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Min. | Min. | 3 / 1 / 1 9 4 2 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** 1 M X X 69 Maryland 216-38-3903 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 □Yes XNo MD Harford Whiteford Director 10g, Citizen of What Country? 10f, Zip Code 10e. Street and Number 21160 USA 2140 Linebridge Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12, Was Decedent Ever in U.S. Armed Forces? 11. Marital Status within 72 hours after 1 ☐ Yes 2 No 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2√□ No White Specify: þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) marked other than College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fi Virginia Booth Roland Knight, Sr. . Pages 1 and 2 should by iment of Health and Mentitant; If item 27 is marked 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Edward G. Winesett-husband 2140 Linebridge Rd., Whiteford, MD 21160 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bel Air Mem. Gdens 12/29/11 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of
Important: If it
any injury or or 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air, MD 22. Name and Address of Facility 21. Signature of Funeral Service/Licens C. Kobert Harkins F.H.Inc.,600 Main St.Delta,PA 23a. Part 1. Enter the disease, of complications that caused the early. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or a a consequence of): **Examiner** 10/10/11/4 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami certificate be execu Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2 ☐No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋧ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed AL 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending P 24 hours after death. Funeral Director: After t 27. Manner of Death After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D Ectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ucysella 30. Name and address of person who completed cause of death (Item 23a) (Type, Print ,500 Upper Chesapeake Dr., Bel Air, MD 21014 Kimberly T. Russell

DHMH 17 Rev 1/2001

State Registrar

State Registrar

DHMH 17 Rev 1/2001

OCME 2006

32. Registrar's Signature

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

Zabiullah Ali, M.D.

31. Date filed (Month, Day, Year)

November 30, 2011

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>011</u> Physician/ Month Karon Yeatman 9:46 A M Dec Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Deale Anne Arundel <u>5872 Swamp Circle Road</u> 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Days Hours 1 □ M 2 🔽 F Oct.16, Washington DC Director 47 Yrs 1964 212-66-2820 Usual Residence of Decedent 28a-f show 10b. County : If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 XNo Maryland | Anne Arundel Deale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5872 Swamp Circle Road 20751 USA Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2XX Married Baltimore, Maryland 21215-0036 Yes 2XXNo If Yes, Give Year or Dates 1 Tes 2 YNo Specify. White 3 Widowed 4 Divorced Specify. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Sue Bond Rye Carolyn Donald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Robert Yeatman- Husband 5872 Swamp Circle Road, Deale, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Dec. Date 3, permit. Page 1 Department of Important: If it any injury or o of Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Trinity Memorial Gardens 2011 Waldorf, Maryland 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. . Signature of Funeral Service Licensee Carry 3. GOIT Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Arama disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** LINI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician a s the burial-1 Physician/Medical Box 68760 as ves, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Successful at time of death 5 Other (specify) IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 100

9 Unknown for Month Day Year P.0. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy performe of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending Division nours after death neral Director: A ifilled in by the fi Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u> 2003 Medical Parkway, Wayson Bldg Suite 301, Annapolis,MD 21401</u> Dr. Neisenberg 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ а м 20118:15 Jean Marlene Patton Yancey December Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral (Month, Dav. Year) 579-38-6473 **Director** 1 □ M 2 🏝 F 79 June 30, 1932 Washington, DC 28a-f shov 10b. County 10c. City, Town or Location at 10a State Director notified 1 Yes 2 No Hyattsville P.G. MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 0 an "natural", or items 23a or Medical Examiner must be r Funeral 20783 USA 9103 Adelphi Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Force Yes, specify Cuban, Mexican, Puerto Rican, etc. rces:/ 2 ☐ No 1 Never Married 2 Married þ Specify: Black Baltimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Computer Scientist Technology Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Should be file and Mental F ပ Mary Davis Columbus Patton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 9103 Adelphi Road, Hyattsville, MD 20783 Charles W. C. Yancey/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place
George Washington 20c. Location - City or Town, State Date 1 K Burial 2 Cremation 3 Removal from State Dec. Adelphi, MD $201\overline{1}$ 4 ☐ Donation 5 ☐ Other (Specify) emetery 21. Signature of Fineral Service Licensee 2. Name and Address of Facility rancis J. Collins Funeral Home Inc. O University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ End-Stage Renal Disease disease or condition Medical resulting in death) **Examiner** Osteomyelitis Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death the 9 Unknown 9 Unknown signed by ti d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 😾 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific bompletely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 1 ☐ Yes 2 🔀 No ပ္ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) Dec. 16, 2011 D45471 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

Yeheyis Negussie, MD

DEC 2 0 2011

31. Date filed (Month, Day, Year,

32. Registrar's Signature

1111 Spring Street, #214, Silver Spring, MD 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 920 PM Month 2 Physician/ Zacks Fannie 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1801 East Jefferson Street Rockville Montgomery 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** Days Months Min 1 □ M 2 😾 Hours 12/28/1913 NY NY 97 Director Yrs 085-03-8402 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 TyrYes 2 I No MD. Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1801 East Jefferson Street 20852-4056 United States "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No If Yes, Give be filed within 72 hours after Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🛛 No Specify: 3 → Widowed 4 □ Divorced Specify. Year or Dates id Mental Hygiene. marked other than "natur matic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Bessie Lockswevity Samuel Jablonsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bethesda MD 20814 Barbara Zacks Herson - daughter 5225 Pooks Hill Road #1101 South 20a. Method of Disposition
1 X Burial 2 Cremation 3 X Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 12/13/11 Paramus, NJ 4 Donation 5 Other (Specify) Cedar Park Cemetery 21. Signature of Fun ral Ser in Line 22 Name and Address of Facility Edward Sage | Funeral Direction Inc. 1091 Rockville Pike Rockville MD 20852 M01163 23a. Par mer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or conditi resulting in death) Thrive Failure to Medical Due to (or as a consequence of) Examine Dyspagia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examine Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Dementia the burial-trans the attending physician and hed for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month 4 ☐ Pregnant g ☐ Unknown Pregnant at time of death detached g Unknown n signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed upleted filled in by the funeral director, page 2 should 24 hours after death.

Funeral Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performe death? performed? Yes_ 2 XNo 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 X No Hospital: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 22
To the I

State Registrar

only one)

A. Chilakamarri

DEC 1 5 2011

31. Date filed (Month, Day, Year)

WD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

1801

29c. License number

D69568

E Jefferson street Rockville MD

29d, Date signed (Month, Day, Year)

20852

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death 09,2011 Physician/ 3:55a M Meyer Zlotnik December Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4925 Battery Lane Bethesda Montgomery Social Security Number 7. Age (In vrs. last birthday, If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 132-05-1561 **Director** 1 X M 2 🗆 F 95 New York April 16.1916 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location with the Maryland must be notified at 10d. Inside City Limits Director Maruland Montgomery Bethesda 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 4925 Battery Lane 20814 U.S.A. death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Examiner Black White etc. þ 1 Never Married 2 Married Yes ! Baltimore, Maryland 21215-0036 be filed within 72 hours after 1 Yes 2 X No Specify: 'natural", Completed 3 Nidowed 4 Divorced WWII White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) d Mental Hygiene. marked other than life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Stocks Δ Broker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Nathan Zlotnik Rebecca Rakowski and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sh tment of Health a tant: If item 27 i Marc Zlotnik - Son 9926 Derbyshire Lane, Bethesda, Maryland 20817 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 🕱 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Garden of Remembrance 12/11/2011 | Clarksburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave. Silver Spring. MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ disease or condition resulting in death) Lung Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or i Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O, Box 68760 phy attending properties of the second se IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Dav Year 2 No ed by the a 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page performed? Yes 2 X No death? certificate 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner' Hospital 2 X No Other: 1 🗌 Yes ျ this 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending s after death. Accident 1 Tyes the Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Funeral I Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar

State

12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D.,

32. Registrar's Signature

Ava A. Kaufman,

15 2011

31. Date filed (Month, Day, Year)

D26259

8218 Wisconsin Ave., #103, Bethesda, Maryland 20814

December 09, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Derek Tyron Austin	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 20	1 4281
Physician/ Medical Examiner	1 Decedent's Name (First, Middle,Last) 2. Date of Death	3. Time of Death 2112 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 10950 Piscataway Road 4c. County of De Prince Geor	
Funeral Director	Montes Days Hours Will. 4 4 / 0 0 / 0 0	Birthplace (State or seign Shithngton Do
any	229-45-3033 1 M 2 F 28 Yrs. 11/22/83 Wa. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
aryland 8a-f show at once.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Prince George Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What C	1 X Yes 2 No ountry?
with the Maryland is 23a or 23a-f sho	12016 Deka Rd 20735 USA	nerican Indian, Black,
s after death with rral", or items 23 oliver must be no by Funeral		lack
6 172 hour nn "natu cal Exan	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business during most of working life.	ss/Industry
21215-0036 ould be filed within 7 I Mental Hygiene in event, the Medica TO Be Comple	12 Field Tech. Comcas 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	<u>t</u> _
MD 2121 (d 2 should be fill thand Mental Fill no 27 is marked numatic event, 1	2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St.	
ore, Was 1 and 2 of Health If item 2	Nanci Austin Giwa-Mother 12125 Sierra Sunset Ln, Gainesvil 20a. Method of Disposition 2Cb. Place of Disposition (Name of cemetery, 1	or Town, State
Baltimore, permit. Pages I an Department of Hea Important: Uffer	4 Donation 5 Other Specify: 1—5—12 Resurrection 1/6/12 Clinton 21. Signature of Funeral Service Licensee 22. Name and Address of Facility	
Physician	Adams Funeral Home Pa, Aquasco 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	MD 20608 Approximate Interval Between Onset and Death
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aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Dicease or it july that it it listed avents resulting in death.) Last Due to (or as a consequence of):	
50, e be executed sysician and burial - transit ledical Examiner	events resulting in death) Last Due to (or as a consequence of): d. UNPENDED AMENDED	
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ion of Vital Records, P.O. Box 6876(reading Physician: The law requires that the death certificate sath. or: After this certificate has been signed by the attending phys the funeral director, page 2 should be detached for use as the atton: To Be Completed by Physician/Me	24a. Was an 1 24b. Were autopsy performed? death	
Vital Rec ysician: The his certificate director, page	25. Was case referred to medical as a sample of Death (Check only one)	
n of Vi ding Physi L. After this funeral dir	1 Yes 2 No 1 inpatient 2 EN/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 V Ot	
·	Natural 5 Pending Investigation 2 Accident 2 Accident 2 Se. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) determined (Specify) Major Poad / Highway 10950 Piscataway Road Clinton	-
		tated.
To the Howithin 24 To the Fu completel		
	Theodor We tog Thyma O.C.M.E. December 24,	2011
BQ-4	30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State Registrar	31. Date filed (Month, Day, Year) DEC 28 2011 32. Pegistrar's Signature	

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Examin	er			n, give street and number) road Trail			4b. Cit		r Location of Death Idywine		4	c. County o Prince		orgo	
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Page on the page of the page o		1 ဩ Burial 2 4 ☐ Donation	☐ Cremation 5 ☐ Other (3 ☐ Removal from State Specify)		cemetery, cren Vary 1 and			emetery 12	/27/2011	m-	inton.	MD		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		21. Signature of Fur				22	. Name a	and Addres	ss of Facility Le	e Funeral	Home			Old Alexa	ndria
ă∆ ⊆ ≅ ö l		Sawa	X	sout ma	25				Clinton,						
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Physician/		disease or condition resulting in death)		a. Due to (or as	a conseq	uence of):	LLAN	<i>Cev</i>	_					1 year	
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the Hin 24 the Figure 14 the F	Mec	only one) 3	Certifying	Examiner: On the basis of e Nurse Practioner: To the			death occ	curred at th	e time, date and pla		ne cause	e(s) and mar	ner as s	tated.	er stated
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Haresenia Asmond December 2011 21:30 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery ecurity Numbe If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 579-64-0902 1 □ M 2XX **Director** 63 Oct. 19, 1948 South Carolina Usual Residence of Decedent 28a-f show 10a. State 10b. County ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's 1 X Yes 2 No Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12605 Asbury Drive 20744 United States death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Examiner Black. White, etc. 9 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after 1 Yes 2 No Specify: "natural" 3 Widowed 4 X Divorced Specify: Black Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 years Psychiatric Counselor Government 17. Father's Name (First, Middle, Last) 1 and 2 should be filed of Health and Mental Histem 27 is marked of 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Edward Asmond Ethelmae Hollaway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rhonda Williams - Daughter 12605 Asbury Drive Fort Washington, MD 20744 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o Page 1 **★** Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Heritage Mem. Cemetery Dec. 29, 2011 Waldorf, MD Signature of Funeral Service Licensee 22. Name and Address of FacilityStewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Massive Hemoptysis disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Severe Thrombocytopenia institution list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami Metastatic Small Cell Carcinoma Lung Due to (or as a consequence of) attending physician for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 XNo Month Dav Pregnant at time of death ed by the a detached i Unknown Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? Yes 2 X No certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 X No မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27 Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural work?
1 Yes 2 No injury Accident 5 Pending s after death.

I Director: A in by the force of the forc Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical within 24 hound to the second 29a, Certifier **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) MD DOO 63639 22

State Registrar Date filed (Month,

DEC 2 8 2011

Yvonne N. Rudder, M.D. 1500 Forest Glen Road Silver Spring, MD 20701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ам Alice Ethel Bowling **Medical** 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death IVISTA a If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9. Birthplace (State or Foreign **Funeral** . Age (In yrs. last birthday) 1 □ M 2 🕽 F Days 88 Months Hours Min (Month, Day, Year Faulkner Director 214-90-6910 1923 6. June Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Charles La Plata 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 10200 La Plata Road United States permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner on 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc. 1 X Never Married 2 Married þ If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Disabled Disabled Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Thomas W. Bowling Daisy M. Simpson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl D. Hornbeak/Nephew Eilerson Street Clinton, MD 20735 Baltimoré, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Dentsville Methodist 12-29-2011 Dentsville, Maryland 21. Signature of Juneral Service Lies 22. Name and Address of Facility Arehart-Echols Funeral Home, P.A. M01458 211 St. Mary's Ave. Box 567 La Plata, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Monio days disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury and -tran that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 attending p 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) signed by the a d be detached for 1 ☐ Yes ∠ □ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an l director, page 2 autopsy performe 1 Yes 2 No 1 Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 1 🗌 Yes 2 🗷 🛶 မြ 1 npatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at After Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No n 24 hours after death.

e Funeral Director: A bleted filled in by the fu Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 24

To the Fi 3 only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue, La Plata, MD 5 Mcheli velisse 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

D.C

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2011 42821 State of Maryland / Department of Health and Mental Hygiene Shadaya Nelda Brady 1-For State Amend#1permedical exam Gartificate of De2012bb Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day December 30, 2011 Medical Examiner 2352 hrs SHADAYA NELDA BRADY BRADDY 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death LaPlata Charles Civista Medical Center 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign Country) WASHINGTON. Min Months Davs Hours Director NOVEMBER 3, 2007 579-45-1658 1 M 2 X F Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location NORIH 1 Y Yes 2 No DURHAM DURHAM **CAROLINA** permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-7 sho 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? UNITED STATES 1801 WILLIAMSBURG ROAD, APT.#31E 27707 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married 2 X No 1 Yes Specify: BLACK 4 Divorced f Yes, Give Year 1 Yes 2 No specify: 3 Widowed \$ 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) **EDUCATION** STUDENT 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) SHELLY LEE BRADDY Be DAVID BERNARD TAYLOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVID BERNARD TAYLOR / FATHER 1801 WILLIAMSBURG ROAD, APT.#31E, DURHAM, NORTH CAROLINA 27707 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 XBurial 2 Cremation 3 Removal from State JANUARY 10,2012 STLVER SPRING, MARYLAND GATE OF HEAVEN CEMETERY 4 Donation 5 Other Specify 21 Sunature of Funeral Service Louisee THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, LYDLA C. THORNTON JOHNSON MOO583 MARYLAND 20640 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line (Medical Death Immediate Cause (Final disease a. Undetermined Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Physician/Medical AMENDED 23a, 27, 28a-f, per me, g925 3-7-12 sm physician the burial -X UNPENDED Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death Live birth 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. Ś 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy performed? death? Yes 2 No 1 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: Division of Vital Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 Inpatient 2 Other Nursing Home 5 Residence 6 Other 1 Yes 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification Natural 1 Yes 2 X No unknown 5 Pending fd 12-30-11 death. Director: fd 5:00 pm 2 [Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be Suicide or Town, State) determined (Specify) 24 hours a unknown unknown Homicide 29a. Certifier 1 (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <u>eg</u> 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number January 1, 2012 O.C.M.E. Whella 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Laron Locke MD. 31. Date filed (Month Par Year) 32. Ragistrar's Signature State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

OCMF

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Debra A. Bagent State of Maryland / Department of Health and Mental Hygiene 2011 42822 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day December 29, 2011 Medical Examiner 0810 hrs Debra Ann Bagent 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 10221 White Pelican Way **New Market** Frederick 9. Birthplace (State or Foreign Washington 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY **Funeral** Months Days Hours Director 215-84-4741 50 June 27, 1961 1 M 2 X F Country) Yrs DC. Usual Residence of Decedent 10d, Inside City Limits 10b. County 10c. City, Town or Location New Market Maryland Frederick or 28a-f show 1 Yes 2 X No notified at once. with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10221 White Pelican Court 21774 United States of America 23a Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, must be death 1 1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Yes 2 X No þ permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", o injury or other traumatic event, the Medical Examinet. White If Yes, Give Year 1 Yes 2 X No specify: 4 Divorced Specify: ۾ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Itimore, MD 21215-0036 Own Home 9 Homemaker: 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Daniel E. Wilson Roxie Tothill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10221 White Pelican Court, New Market, Maryland 21774 William Glenn Bagent / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c, Location - City or Town, State crematory or other place? 1 X Burial 2 Cremation 3 Removal from State January 6, Rockville, Maryland Parklawn Memorial Park 2012 Donation 5 Other Specify. 21. Signature of Pupleral Service Lig Reeney and Basford P.A. Funeral Home M01433 106 East Chuch Street, Frederick, Maryland 21701 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Combined effects of Morphine, Methadone, Hydromorphone **Physician** Approximate Interval Between Onset and Madies Death a and Amitriptyline chronic obstructive pulmonary disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequençe of): Esquentially fist conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed AMENDED 23a, 27, 28a-f, per me, g923 1-20-12 sm e attending physician a for use as the burial -X UNPENDED Physician/Medi Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery dent pregnant in the 2 Fetal death 1 Live birth 3 Ectopic pregnancy Month Year Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Completed ficate has been s page 2 should b 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed' ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Division of Vital Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other: Scene 2 ER/Outpatient 3 DOA After this 1 Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural subject ingested medications 1 Yes 2 X No hours after death. Pending the f fd 12-29-11 fd 8:00 am 2 X Accident Investigation filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 10221 White Pelican Way. New Market, MD. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be within 24 hours a To the Funeral I determined residence 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal the 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 30, 2011 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, 32. Registra/s Signature State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

OCME

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

	1	For State Registrar	Pleas	se Type or Pri State of M		d / Depa		of H	lealth and	_		e 201		+2823	
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Examine	r		CK MEMOR	ive street and number) IAL HOSPITA . Sex 7. Ac		ast birthday)	4b. City, T FREDI	ERIC	Location of Death		F	c. County of Dea		State or Foreign	
Director		217-60-54 Usual Residence of	414 Decedent		59	Yrs.	Months	Days	Hours Min.	Aprit, D	23°,	1952 Wa	shing	ton D.C.	
Maryland 28a-f sho	irector	10a. State MD		erick	10c. Cit	y, Town or Loc Frede	rick						1 [Side City Limits Yes 2 No	
th with the ms 23a or must be r	Funeral Director			er Drive		. La		702		- 1 V - N	Uni	Citizen of What Co. ted Sta	tes		
mir i	≥	11. Marital Status 1 Never Marri 3 Widowed	4 Divorced	If Yes, Give Year or Dates.		If	Vas Decede Yes, specif	y Cubar	spanic Origin? (Sp n, Mexican, Puert Specify:	oecity Yes or No o Rican, etc.))-	14. Race - Am Black, Whi Specify: Wh	te, etc.	an,	
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permit Depar Impor any in		21. Signature of Fur	. How	الم	MO161	22 K	Name and eeney 06 E.	Addres & I Chu	Basford Jrch St.	Funeral , Frede	Hon rick	ne k, MD 21	701		
Physician/ Medical		23a. Part 1. Enter the shock, or hear immediate Cause (disease or condition resulting in death)	rt failure. List onl Final	omplications that cause y one cause on each lin a. Cardio	e. oulmo	nary A	r the mode	of dying	g, such as cardiac	or respiratory a	arrest,		Appro Interv	oximate val Between t and Death	
Examiner	ner	Sequentially list con if any, leading to im	nmediate	b. <u>Hyperte</u> Due to (or as									199	8	
be executed sician and burial-transit	cal Examiner	cause. Enter Under Cause (Disease or that initiated events resulting in death) I	linjury s	c. <u>Hyperl</u> Due to (or as								1999			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	~ !	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Feta	al death 3	Ectopic pr Other (spe		y			23d. Date of do	elivery Day	Year	
nires that the signed by alid be detacted	ed by Pr	Part II. Other signif	icant conditions	s contributing to death t	out not res	ulting in the u	nderlying ca	ause give	en in Part I.			use contribute t			
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ending Phy eath. or: After this he funeral d	Certificate: 10	27. Manner of Death 1 🔀 Natural 2 🔲 Accident	n 5 ☐ PendingInvestiga	28a. Date of inju (Month, Da	ıry	28b. Time of injury		c. Injury work?	at	28d. Describe		6 ☐ Other (Speury occurred	city)		
ital or Atte urs after de al Directo led in by th	al Certi	3 ☐ Suicide 4 ☐ Homicide	6 L Could no determine				et, factory,	office		28f. Location City or To		ind Number or Ri te)	ural Route	Number,	
the Hospi hin 24 hou the Funer upleted fil	Medical	(Check 2 only one) 3	☐ Medical Exa ☐ Certifying N	hysician: To the best of nminer: On the basis of e urse Practioner: To the	examination	n and/or invest	igation, in m	y opinior ed at the	n, death occurred time, date and pla	at the time, date	and place	ce, and due to the	cause(s) a	nd manner stated.	
\$ \$ \$ \$ \$		29b. Signature and	title of certifier	Ao h	برر	li		License 2660	number			28/11	th, Day, Ye	ar)	
John.		Joseph A	Ashwal,		omas	Johnso	^{rint)} n Dr		rederic	k, Md.	217	01			
State Registra		31. Date filed (Mont)		32. Registr	ar's Signat	park									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Joseph Russell Cefaratti December 2011 7:50 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Prince Georges HCR Manor Care Largo Largo 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. Hours Min. . Sex . Age (In yrs. last birthday) If Under 1_Year 9. Birthplace (State or Foreign **Funeral** Days Months 86 048 14 4380 1 X M 2 □ F Director July 13, 1925 New Britain, CT Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified 28a-f 1 Tes 2XX No Seat Pleasant Maryland Prince George's 10f, Zip Code 10e, Street and Numbe 10g. Citizen of What Country? ö items 23a or ner must be n Funeral 20743 United States 115 Peppermill Drive Page 1 and 2 should be filed within 72 hours after death \u00e4ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces?

1X Yes 2 No
If Yes, Give 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. White 1947 3 Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) the NOAA Meteorologist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F 27 is marked of traumatic even ပ Theresa Demao -CeFaratti Anastasio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond CeFaratti (Son) 5209 Cottonwood Drive, Lothian, MD 20711 Department of Healt: Important: If item 2 any injury or other I 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cemetery Jan 10, 2012 Arlington, Virginia ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lie mois 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a. Pgrt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Pulmonary Failure disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Dementia Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician by Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 1 ☐ Yes 2 ☐ Unknown detached 9 Unknown the s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy 1 ☐ Yes 2 🕱 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital မ 1 Tes 2 **XX**No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending work? 1 🗌 Yes 2 🗎 No s after death.

I Director: Aft Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a fo the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 29b. Signa 29d. Date signed (Month, Day, Year)

BO TUA State

State Registrar 31. Date filed (Month, Day, Year) 32. Fegistrar's Signa Registrar

address of person who

BAHRAM

Putpap, MD 1328 Southern Ave, S.E. Washington, DC Year) 32. Begistrar's Signature

ompleted cause of death (Item 23a) (Type, Print)

1) 51520

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42825 Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ 10:05 Medical 201 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death University Maryland Medical Baltimore MD If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months Hours 1 🔀 M 2 🗆 F Country) Washington DC Director 220-38-3471 69 1 9 4 2 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 ☐ No MD St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21895 Pegg Rd. 20653 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bus Driver Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Samuel Henry Cradle Annie O'dell Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21895 Pegg Rd. <u> Martha Bradlev/Sister</u> Park, Lexington MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ee Cemetery 12/30/11 Oakville, MD 22. Name and Address of Facility Briscoe-Tonic Funeral Home 21. Signature of Funeral Service Lig Washington Rd Waldorf MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Boknior Immediate Cause (Final Physician/ Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of): € Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a conseduence on attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death Month Year signed by the at d be detached for Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 To the Hospital or Attending Physician; The within 24 hours after death.

To the Funeral Director; After this certificate I performed Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes Other: 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manne T Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 Yes 28b. Time of 28d. Describe how injury occurred Natural injury 5 Pending 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

Date filed (Month, Day,

32. Registrar's Signature

una

7 2011

State Registrar 1 our

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NCXVI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SUN EI DILL Month Medical Facility Name (if not institution, give street and number) Examiner cation of Death If Unde 8. Date of Birth (Month, Day, Ye JUNE 24 7. Age (In yrs, last birthday) If Under **Funeral** g. Birthplace (State or Foreign Months Days Min. 85 SOUTH Director Yrs 214-68-8975 1926 KOREA Usual Residence of Decedent "natural", or items 23a or 28a-f shov 10a. State 10b. County Examiner must be notified at 10c, City, Town or Location Director 10d. Inside City Limits CHARLES LA PLATA 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1005 AGRICOPIA DRIVE 20646 U. S. A. 12. Was Decedent Ever in U.S. 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify 3XXVidowed 4 ☐ Divorced ASIAN traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 (UNAVAILABLE) (UNAVAILABLE) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 BELLA CURTIS / DAUGHTER 1005 AGRICOPIA DR., LA PLATA, MD 20646 injury or other Baltimoré. 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition permit. Page 1 a
Department of F
Important: If ite 20c. Location - City or Town, State JANUARY 1 Burial XXCremation 3 Removal from State METRO.CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 1, 2012 ALEXANDRIA, VA ture of Funeral Service Lice 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Immediate Cause (Final nset and Death Pnysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 Probably 4 Unknown Completed peen Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy 2 4 1 Yes 2 No Yes 25. Was case referred to medical the funeral director. Be 26. Place of Death (Check only one) examiner? 2 No 2 1 🗌 Yes ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) . Mayner of Death Certificate: Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination alrayor investigation, it my opinion, seath occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the l within 2 To the F only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) leted cause of death (Item State

Registrar

1/2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 | | 42828 For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Denney Helen Jean December 2011 5:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3230 Basford Road Frederick Frederick 8. Date of Birth (Month, Day, Year) Social Security Number Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours Min Director 018-18-1035 1 🗆 M 2 🕱 F 90 October 5, 1921 Massachusetts Usual Residence of Decede show the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f Maryland Frederick Frederick 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö ral", or items 23a c Examiner must be Funeral 3230 Basford Road 21703 States United 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 No Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White "natural", Completed 3 XWidowed 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Hygiene. other than Elementary/Secondary (0-12) Nurse Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental marked o ည if Health and Ments item 27 is marked other traumatic e Joseph A. Burns Isabella MacDonald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maureen Boggs/ Daughter 3230 Basford Road Frederick, Maryland 21703 item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any injury or oth 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Petersville, Maryland St. Marys Cemetery <u>January 3,2012</u> 22. Name and Address of Facility Keeney and Basford Funeral Home 21. Signature of Funeral Service 106 E. Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the diseas , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure List only one cause on each line Immediate Cause (Final disease or condition Physician/ Arteriosclerotic Cardiovascular Disease Medical resulting in death) Due to (or as a consequence of) Examiner Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (bride a consequence of, the attending physician and hed for use as the burial-transit Due to (or as a consequence of) Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 Month Day Year Yes 2 X No detached 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 24 hours after death. Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed peen Were autopsy findings available prior to completion of cause of 24a. Was an has perform death? this certificate 1 Yes 2 X No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 💢 No Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 X Other (Specify) Dtr. Residence filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No XNatural 5 Pending 2 Accident
3 Suicide Investigation Director 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D22037 December 29, 2011 Lerno 10 pm 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

Leonard C. Kinland

JAN 1 0 2012

M.D.

32. Registrar's Signature

610 Ninth Avenue, Brunswick, Maryland 21716

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | | 42829 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Timothy Daniel Day 2304 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HICOMICO REGIONAL 544156414 Age (In yrs. last birthday) If Under Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Min. Hours 215-54-6788 **Director** 1**X** M 2 □ F 51 8/12/1960 MD Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits at 10a. State Director notified 1 X Yes 2 No Ocean City MD Worcester 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ò must be r with 1 Funeral 21842 USA 181 Jamestown Rd. items death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-"natural", or iten edical Examiner n 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 Married þ hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify 3 Widowed 4 Divorced white Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene. 27 is marked other than r traumatic event, the Me other than Elementary/Secondary (0-12) College (1-4 or 5+) Tile Tile Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Shirley Stahl Donald E. Day 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heath ar Important: If item 27 is any injury or other trau once. 1846 Meridian Dr., Hagerstown, MD 21742 Shirley Day / Mother Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 A Cremation 3 Removal from State First State Crem. 12/21/2011 Millsboro, DE 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service 22. Name and Address of Facility Burbage Funeral Home Signati 108 William St., Berlin, MD 21811 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying SUSKM The law requires that the death certificate be executed the burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year Month Pregnant at time of death n signed by the at tid be detached fo 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Hinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 TNo မြ 1 Thipatient 2 ER/Outpatient 3 DOA funeral 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: Accident 1 Natural 5 Pending s after death.

I Director Aft
d i by the fur 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled i by 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 24 hou

To the Fune

completely fi 29a, Certifier Médical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

auge

W 31. Date filed (Month, Day, Year) 3001

RNP

32. Registrar's Signature

dman

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Camil street Salisbum MD21801

3a or 28a-f show t be notified at 27 is marked other than "natural", or items 23a traumatic event, the Medical Examiner must be filed within 72 hours after death Baltimore, Maryland 21215-0036 should be filed within and Mental Hygiene. permit. Page 1 and 2 sh Department of Health a Important: If item 27 is 9 Physician/ Medical Examiner requires that the death certificate be executed physician and the burial-transit Box 68760 attending pl been signed by the should be detached P.0. Records, page To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital

1 - State Registrar

10a. State

Maine

Director

Funeral

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Examine

Physician/Medical

Completed by

Be

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Certificate:

Medical

IF FEMALE

examiner's

29a. Certifier

29b. Signature and title of certifie

14

1 Yes

Physician.

Medical

Examiner

Funeral

Director

amend 30 per DVR, g923 1-10-12 sm Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Carlos Alfonso Espana 1455 PM Occember 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Hagerstown Meritus Medical Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)1923 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 ★ M 2 □ F Hours. Country) 571-40-0130 88 August 13, <u>Ouatemala</u> Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits Free Port Cumberland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 04032 59 Bowden Lane U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Mo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1X Yes 2 \square No Specify: Quatemalian White Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Architect 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Aurelio Pena Luisa Espana 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 59 Bowden Lane Free Port, Maine 04032 Socoro Espana (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) December 1 Burial 2X Cremation 3 Removal from State Smithsburg, Maryland 4 Donation 5 Other (Specify) Smithsburg Crematory 30, 2011 J.L. Davis Funeral Home Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. Smithsburg, Maryland 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SEPTIC SHOCK disease or condition resulting in death) ypoxic respiratory failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of resulting in death) Last 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 1 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No М Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Сетибуло Nurse Practioner. To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar Ramesh Kumar 827 Linden Ave. Baltimore, MD, 21021 Signature

M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEN AMANDA KRISTINE FIELDING Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner NATIONAL INSTITUTES OF HEALTH BETHESDA 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of (Month **Funeral** 1 □ M 2 🛛 F Days Hours Min. Yrs Director 431-81-9560 April Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if frem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Evanium. 10a. State 10b. County 10c. City, Town or Location Director AR Benton Lowell 10e. Street and Numbe 10f. Zip Code by Funeral 14338 Frisco Spring Road 72745 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Completed Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education (Specify only highest grade completed)

College (1-4 or 5+)

			DECEME	EK .	24 2	.011	0:22	PM
TH	4b. City, Town, o	r Location of Death DA		4	c. County	of Death	CRY	
n yrs. last birthday) 27 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D April	rth av Year) 12,	1984	9. Birth Cour	place (State or antry) GA	Foreign
0c. City, Town or Lo	ocation						10d. Inside City	Limits
Lowell							⊅ Yes 2	2 🗆 No
	10f. Zip Code			10g. 0	Citizen of \	What Cou	ntry?	
	72745			Uni	ted	State	es	
r in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No Rican, etc.)			e - Ameri ck, White,	can Indian, etc.	
	1 ☐ Yes 2X No	Specify:			Specify	Whit	:e	
I (Give	dent's Usual Occup kind of work done O NOT use retired)	durina most of work	ing	16b.	Kind of B			
Barter	_			Pr	ivat	e		
18. Mother's Name (First, Middle, Maiden Surname) Polly Lynn Martin								
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14338 Frisco Spring Road, Lowell, AR 72745								
20b. Place of Dispo cemetery, cree Riverdale	osition (Name of	• "	Data	200	Location .	City or T	own State	
1 15 22	2. Name and Addre		pe Fune	eral	Home	es, I		
e death. Do not ent					110,		Approximate Interval Betwo	
onsequence of):							2 WEEKS	3
onsequence of):								
onsequence of):								
	Ectopic pregnand Other (specify)	Э				te of deliventh	rery Day Ye	ar
not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to						ribute to t	he cause of dea	ath?

3. Time of Death

Physician/ Medical Examiner

the burial-tran

Hospital or Attending Physician: The law requires that the death certificate be executed

within 24 hours after death.

To the Funeral Director, After this certificate has been signe completed filled in by the funeral director, page 2 should be a

To the Hospital within 24 hours a To the Funeral D

Box 68760

Division of Vital Records, P.O.

Examine

Physician/Medical

Be Completed by

Certificate: To

Medical

29a. Certifier

2

IF FEMALE:

Be

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Sequentially list conditions, if any, leading to immediate Cause (Disease or linjury that initiated events resulting in death) Last

23b. Was decedent pregnant in the past 12 months?
1 Yes 2 X No 9 Unknown

Immediate Cause (Final

disease or condition

resulting in death)

Elementary/Seconday (0-12)

17. Father's Name (First, Middle, Last)

Kenneth Fielding

19a. Informant's Name/Relationship (Type, Print)

4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lio

<u> Kenneth Fielding / Father</u>

1 Burial 2 Cremation 3 Removal from State

12th

20a. Method of Disposition

C.	Due to (or as a consequence of):
d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SEPSIS

	3 Ectopic
4 Pregnant at time of death	5 Other (sp
9 Unknown	

M01083

Due to (or as a consequence of):

Due to (or as a consequence of):

BACTEREMIA

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator shock, or heart failure. List only one cause on each line.

3 ☐ Ectopic pregnancy 5 ☐ Other (specify)

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,	IX.	Nlo	۰. 🗆	Drobo	bly	ı 🗆	Unkne	

GATA 2 DEFICIENCY

MONOMAC	

MOLING		
case referred to medical		26. Place of Death (
miner?	Hospital:	Other

J	1 ☐ Yes	2 X] No	3 🗌 Probably	4 🗌 Unknow
	24a. Was an autopsy		24b.	Were autopsy fin prior to completi	dings available on of cause of

5. Was case referred to medical		
examiner? 1 ☐ Yes 2 🗵 No	Hospital: 1 X Inpatient 2	2 ER/Outpatient
7 Monney of Dooth	Office Date of injury	20h Time of

performed? death? 1 Yes 2 No 1 Yes 2 No	
(Check only one)	

examiner? 1 Yes 2 X	No	Hos	spital: 1 🛛 Inpatient 2 [
. Manner of Death 1 X Natural 2 Accident	5 Pending		28a. Date of injury (Month, Day, Year)
3 Suicide 4 Homicide	6 Could not be determined	e	28e. Place of Injury - At

DOA	Other.	☐ Nursing H	ome	5 🗌 Residence	6 Other (Specif
	Injury at work?		28d.	Describe how inj	ury occurred

investigation			
6 Could not be determined	28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory,	office

9	6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify		ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
1	Certifying Physici	an: To the best of my know	ledge, death occured	at the time, date and place, a	nd due to the cause(s) and manner as stated.

(Check only one)					n, in my opinion, death occurred at the time, date occurred at the time, date and place, and due to	e and place, and due to the cause(s) and manner stated. the cause(s) and manner as stated.
29b. Signature a	nd title of certifier	D	reet	- MO	29c. License number ME 106688	29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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10 CENTER DRIVE, BETHESDA, MARYLAND 20892

State Registrar

13

DHMH 17 Rev 7/2009

injury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 42832 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 29, 2011 DEC. JOHN MONROE GRIMES 2:19P M Medical 4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death P.G. CLINTON SOUTHERN MD. HOSP. CENTER If Under Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8-22-1943 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Months Min. WASH., D.C. 220-40-7122 Director 1**X** M 2 □ F 68 Usual Residence of Decedent ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director POMFRET MD. CHARLES 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8835 MARSHALL CORNER ROAD 20675 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc þ 1 Never Married 2 Married 1 Yes If Yes, Give 72 hours after 2 🗆 N Maryland 21215-0036 If Yes, Give ARMY
Year or Dates / IFTNAM 1 Yes 2 No Specify. Specify: WHITE 3 Divorced 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) SELF EMPLOYED PRINTER 9th and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 THOMAS GUY GRIMES ELIZABETH BADEN other traumatic 1 and 2 should by Health and Meinten 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8835 MARSHALL CORNER RD. POMFRET, MD. 20675 BONNIE GRIMES-SPOUSE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 ; Department of Important: If it any injury or of once. 1

Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 ☐ Other (Specify) TRINITY MEM.GARDENS 1-3-12 WALDORF, MD. 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. M00479 PLATA MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ISCHEMIC COLITIS disease or condition resulting in death) Medical **Examiner** DISTASE ARTHGROSCLONUTIC VASCULAR Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events the burial-transit Exam Due to (or as a consequence of): resulting in death) Last physician Physician/Medical P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by SEPSIS Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown this certificate has been signal director, page 2 should PULMONARY DISENSE CHRONIC OBSTRUCTIVE 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 ☐ Yes 2 No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 은 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending iniury work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0064986 12/30/2011 En 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHIKE GREGORY ONWUKA, MD 7503 SURRATTS ROAD CLINTON MD 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar . Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ December 2011 10:05 A M <u>Jeremiah</u> J. Hetherington, <u>Jr.</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 2320 Vern Road Calvert <u>Port Republic</u> Year If Under 24 Hrs. Days Hours Min. 8. Date of Birth (Month, Day, Ye 1ay 20, **Funeral** Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Days Country York 1935 Director 76 May New 106-26-1923 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director 1X☐ Yes 2 ☐ No Maryland Calvert Port Republic 10e. Street and Number ŏ 10f, Zip Code 10g. Citizen of What Country? 23a Funeral 2320 Vern Road 20676 USA items 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc.) ò þ 1 Never Married 2 X Married 2 - No U.S. 72 hours after Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: "natural", If Yes, Give 3 - Widowed 4 - Divorced Completed Year or Dates. Air Force 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Colonel U.S. Air Force Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Jeremiah Hetherington Margaret Johnstone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Scott Santasania/ Step-son 3672 Flamingo Blvd. Hernando, Florida 34607 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory Dec. <u>24, 2011 Glen Burnie, MD</u> 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Huntt Funeral Home MO119\$ 3035 Old Washington Rd. Waldorf, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: signed by the attendin d be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Dav Pregnant at time of death 2 No Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has page performed? Yes 2 N 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After (Month, Day, Year) 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A Accident Investigation Suicide 6
Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier KCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Conffying Nuise Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and itie 29c. License number no completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42834 For State
Registrar Amend#12perfuneralhome1-3-20472ECATA Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dec 23 Physician/ David A. Holt 03:50 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Hours Director 450 66 4155 1 X M 2 - F 67 April 20, 1944 Arizona 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Prince George's Temple Hills 1 Yes 2 X No Mary Land 0 10e. Street and Number 10g, Citizen of What Country? 23a Funeral 4801 Wood Road 20748 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes Phylo Vietnam Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. 1 Never Married 2 Married "natural", or þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: If Yes, Give 3 Divorced 4 Divorced Specify Completed White Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. DOD Retired Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked ျ Henry Kenneth Holt Delpha Lela Mae DaVault 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Holt (Wife) item 27 i 4801 Wood Road, Temple Hills, MD 20748 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I-Important: If ite any injury or ot once, Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Dec. 26, 2011 Clinton, MD Lee Crematory Signature of Funeral Service Licenses 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyin, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine burial-trar Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the SS IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Dav 5 Other (specify) Pregnant at time of death 2 No 9 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy performed? Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 19 No ٥ 1 🗀 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manuar of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 2 Accident
3 Suicide
4 Homicide within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse/Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of contifie

State Registrar DHMH 17 Rev 06-2011 7700 000

32 Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BERWA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death · 1<u>5,2011</u> Physician/ Charles Edward Johnson December 03:43 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince George's Hospital Center Cheverly Prince George's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🔀 M 2 🗆 F Months Hours Min. (Month, Day, Year) 02/14/1936 Country) 579-46-5019 **Director** Wash D Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c, City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. must be notified at Director 10d. Inside City Limits 1√2 Yes 2 ☐ No Md. P.G. Capitol Heights 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral items 23a 6405 Adak Street 20743 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married 1 X Yes 2 If Yes, Give Year or Dates. 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify. '60-'61 Black 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 2 yrs. Minister Clergy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental မ John W. Johnson, Sr. Jeanette M. Wiggins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Charles L. Johnson, Sr. / Son 10902 Rhodenda Ave., Upper Marlboro, Md. 20772 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ò Department of Important: If any injury or once. Harmony Mem. Park 12/21/11 Landover, Maryland 21. Signature of Funeral Service Licensee 2. Name and Address of Facility Henry S. Washington & Sons Co., Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate

Approximate

Approximate Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ monari disease or condition resulting in death) Medical to (or as a consquence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to ou as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Division of Vital Records, 1 🗌 Yes 2 🗋 No 3 🗌 Probably 4 🗗 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an yes 2 No 2 🗌 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 🗹 No 1 Inpatient 2 PER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) eral Director: After th filled in by the funeral 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 29b. Signature and title of certifier R140627 204

CR 5+1

State Registrar

DHMH 17 Rev 7/2009

600 Largo Road, Largo, Maryland

20774

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charissa Boyd, CRNP

31. Date filed (Month

DEC 2 8 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month 12:31AM **Physician** December 2011 Corine Mae Jones /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Somerset Princess Anne Manokin Manor Nursing & Rehab. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1X M 2 □ F March 19, 1921 Maryland 220-03-0195 Director 90 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Menial Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If It is considered to be presented by the construction of the property. 1 ☐ Yes 2 🗓 No Director Maryland Somerset Princess Anne 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21851 USA 27281 Oriole Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No 3altimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 □ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Primary School Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Retha Wigfall Thomas Jefferson Smith ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Deatra Borum/niece 5537 W. Thompson Street, Philadelphia, PA 19131 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State St. James Ch. Cemete. 12/21/2011 Oriole, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 1213 Jersey Road, Salisbury, MD 21. Signature of Funeral Service Licensee 21801 JOLLEY MEMORIAL CHAPEL 23a. Part 1. Enter the disease, or complications that caused the feath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 10 days Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate output, and the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 □Yes 2 □No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ≥ 1 ☐ Yes 2 ☐ Mo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Unursing Home 5 Residence 6 Other (Specify) 1 Yes 2√No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28b. Time of Injury To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After it completely filled in by the funeral 27. Manger of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 □Yes 2 □ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c, License number 29b, Signature and title of certifier who Nah

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

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1415. S. DIVISION

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

USHA NATESAN

Registrar's Signature

0051359

ST, SALISBUMY

December 15th 2011

MD 21804

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lake 2011 Judy Elaine 7:00p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles White Plains 4210 Southwinds Place, Apt. 324 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) Hours 247-94-9415 **Director** 1 🗆 M 2 🔀 F Yrs 61 Usual Residence of Decedent 11-1-1950 Greenville S. iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 K Yes 2 No White Plains Maryland Charles 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20695 USA 4210 Southwinds Place, Apt. 324 "natural", or items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 XNever Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Federal Elementary/Secondary (0-12) College (1-4 or 5+) Program Analyst Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Metts should be Kathleen В. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shi Department of Health an Important: If item 27 is any injury or other trau 4811 Underwood Ct.Waldorf MD 20602 Rolando Smith/Nephew Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 \square Burial 2 \bigcirc Cremation 3 \square Removal from State 4 \square Donation 5 \square Other (Specify) 12/31/201 Alexandria, Va <u>Metropolitan</u> Signature of Funeral Service Licenses Adams Funeral Home Pa, Aquasco MD 20608 heresa 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of law requires that the death certificate be executed sician and burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last ng physician a Physician/Medical Box 68760 attending IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? P Month Year Pregnant at time of death Yes 2 No ed by the a 1 L Yes 2 L 9 Unknown 9 Unknown P.O. I signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa 23e. Did tobacco use contribute to the cause of death? ò Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? death? Hospital or Attending Physician: The After this certificate funeral director, pag 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 🕱 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury n 24 hours after death.

The Funeral Director: Alphetely filled in by the funeral pletely filled in 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 29b. Signature and title 29d. Date signed (Month, Day, Year) of death (Item 23a) (Type, Print) 30. Name and addless of person who GVingin Road, Fort WASNing for Monglant 31. Date filed (Month, Day, Year)
DEC 28 2011 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 1'Z Yea Physician/ 8:08 PM Moylan incont NOZ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University of manyland Medical Center Baltimore, If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Y Birthplace (State or Foreign Country) Social Security Numbe **Funeral** 579-30-3647 N.J. **Director** 1 🔀 M 2 🗆 F 12-7-1927 84 Yrs. Usual Residence of Decedent f show or 28a-f shov notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 X Yes 2 No LA PLATA CHARLES MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or than "natural", or items 23a or the Medical Examiner must be Funeral 20646 U.S.A. 129 MADISON STREET Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

TYPY Yes 2 No ARMY
If Yes, Give 1 9 5 5 - 5 7
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify. Specify: WHITE 3

▼ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industr PRINCE GEORGES CO. al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) FIRE DEPT. (RET.) FIREFIGHTER 12th Be permit. Page 1 and 2 should be file.
Department of Health and Mental Humportant: If item 27 is marrial any injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ PHYLLIS E. RICE VINCENT JOSEPH MOYLAN, SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MECHANICSVILLE, MD. 20659 27022 DOGWOOD LANE KAY PATTERSON-DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date MD. VETERANS CEM. 11-11-2012 CHELTENHAM, MD 4 Donation 5 Other (Specify) 21. Signature of Aneral Service Licensee M00479 2. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician disease or condition maganter 10 ischem 10 Medical resulting in death) Due to (or as a consequence of) Examiner FILDEILLOCKE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and I for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death the a been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Hospital Other: 1 Yes 2 No ၀ 1 Manpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After iniury 5 Pending 1 Natural Investigation Accident Suicide filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 2011 12/29 1871892240 who completed cause of death (Item 23a) (Type, Print) South Greene St. Baltimore, MD 21201 Williams 32. Registrar's gnature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🕦 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ a^{M} Maynard Parmer Marvel, Sr. 28 2011 Dec 9:14 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Gilchrist Center For Hospice Care Towson If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days (Month, Day, Year) Hours Months 215-12-1897 **Director** 1 🗶 M 2 🗆 F June 25,1920 91 MD Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland Director 1 Yes 2 No MD Baltimore Freeland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ŏ "natural", or items 23a o Funeral 19811 Spooks Hill Road 21053 U.S.A. death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?

1 X Yes 2 1 Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify: 945 If Yes, Give Specify 3 Widowed 4 Divorced White Completed Year or Dates. the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Retail Grocery Operator 12 Owner Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Vivian G. Schoal permit. Page 1 and 2 should be Department of Health and Ment Important. If item 27 is marke any injury or other traumatic once. Albert Thomas Marvel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19811 Spooks Hill Rd., Freeland, MD 21053 Margaret A. Marvel Wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion U.M. Cemetery Freeland, MD 22. Name and Address of Facility J.J. Hartenstein Mortuary, 24 N. Second St., New Freedom, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Disease Immediate Cause (Final RINSON Physician/ ears disease or condition Medical resulting in death) ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence oi) The law requires that the death certificate be executed Cause (Disease or injury that initiated events sician and burial-tran Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death the 1 ☐ Yes 2 ☐ 9 ☐ Unknown P.O. signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed? 1 Yes 2 No has death?
1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific, completely filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) WOSDLO 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ည 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles ST TONSON MD 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 12 Month Physician/ 2011 Howard Wellburn Morris 11:57A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester 101 Ocean City 416 Bayshore Dr. Unit Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 6. Sex **Funeral** 1 XM 2 F Days Hours 1/31/1926 85 **Director** 213-20-0980 GA Usual Residence of Decedent show 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 72 hours after death with the Maryland Director Silvens on Mental Hygiene.
and Mental Hygiene.
'is marked other than "natural", or items 23a or 28a-f st 1X Yes 2 No MD Ocean City Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21842 Unit 101 416 Bayshore Dr. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: white 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Sales lanager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fili Department of Health and Mental I Important: If item 27 is marked c any injury or other traumatic eve မ Lillie Mae Sorrells Wellburn Jasper Morris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lark Lane Unit 103 Ocean City MD 21842 Jerry Morris / 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 12/22/11 4 Donation Sunset Mem. Pk. Berlin, MD 5 Other (Specify) ervi Licensee Burbage Funeral Home 22. Name and Address of Facility 21. Signatury 108 William St., Berlin, MD 21811 Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Carcinona PROSTATE CARCINGMA worlde disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed and -tran that initiated events Due to (or as a consequence of): resulting in death) Last signed by the attending physician a Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death 2 No g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ monthicune 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Coronary cate has page 2 s autopsy chality molletin ind 1 Yes 2 No certificate non-25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 1 No 1 🗌 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this ieral Director, After th filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury 1 Natural 5 Pending Accident Sulcide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined hours after within 24 hours a To the Funeral I Medical 1 🖵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier сотріете Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c. License number

Registrar
DHMH 17 Rev 7/2009

State

S. DIVISION ST.

1346

Registrar's Signatur

a. Wennich,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

dneu

5384

SALISBURY MD.

21,2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Lamont December 2011 10:35 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SOUTHERN MARYLAND HOSPITAL CENTER CLINTON PRINCE GEORGE'S Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min 578-72-2042 Director 1**X** M 2 □ F 58 10-26-1953 NE Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits at Director er than "natural", or items 23a or 28a-f s the Medical Examiner must be notified 1 X Yes 2 No Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 7837 Denton Drive 20735 United States death 1 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces' Page 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or 1 Never Married 2 X Married XYes 3altimore, Maryland 21215-0036 2 No 1 ☐ Yes 2 🕱 No Specify: If Yes Give Specify: 3 Widowed 4 Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Realtor <u>Private</u> traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Claude Henry Miller Theresa Henderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) other t Theresa_Brooks/Mother 2266 Sandalwood Drive, Waldorf, MD 20601 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veterans
Cemetery at Chelter 20a. Method of Disposition 20c. Location - City or Town, State Date Department of Important: If i any injury or c 1

Burial 2 □ Cremation 3 □ Removal from State Veterans at Cheltenham 1/04/2012 Cheltenham, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Pope Funeral Homes, P.A. Signature of Funeral Service Light 5538 Marlboro Pike, Forestville, MD 20747 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Cardopulmon Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to infinedia cause. Enter Underlying Cause (Disease or injury signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown filled in by the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has: autopsy performed?

Yes 2 No 1 Yes 2 No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 1 🗆 li patient 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

— Certifying Number Practition of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner To the best of my knowled 29b. Signature and title of certifier 29c. License number P0068207 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20735 VIPUL 160116 7503 DEC 2 8 2011 32. Registre's Sign State all of

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER 2011 7:50P PABLO NICOLAS MENDOZA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NATIONAL INSTITUTES OF HEALTH MONTGOMERY BETHESDA 9. Birthplace (State or Foreign Country) Guayaquil Ecuador Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth **Funeral** 1**X** M 2 □ F Days Hours Min 0272871981 Director 50 Usual Residence of Decedent ıral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director N/A N/AQuito 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Ecuador 170170 Calle Eugenio Espejo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 Never Married 2 X Married Completed by Maryland 21215-0036 1 🕱 Yes 2 □ No Specify: Ecuadorian If Yes, Give Year or Dates "natural" 3 Widowed 4 Divorced Hispanic the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Private <u>Architect</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Gonzalo E. Mendoza Carmen R. Solines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alicia Vasconez/Wife Calle Eugenio Espejo S16-83, Quito, Ecuador 170170 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 12-23-2011 cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State Riverdale, MD Riverdale Park Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility Pope Funeral Homes, P.A. Signature of Funeral Service Licen 5538 Marlboro Pike, Forestville, MD 20747 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ enry disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exam attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2 No. sate has been signed by the page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 **7**No Other: 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) မ ► Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 27. Manner of Death 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Tyes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: On; (Check tioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Prac 29b. Signatur and title of 29c. License number 29d. Date signed (Month. Day, Ye

State Registrar

31. Date filed (Month, Day Year DEC 2 8 201

30. Name and

VDANIEL FOWLER 10 CENTER DRIVE, BETHESDA, MARYLAND 20892 32. Registra s Signature

address of person who completed cause of death (Item 23a) (Type, Print)

01

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Charles Stafford		phy State of I		Depart		Health and		lygiene	2 0 eg. No.	11 4284	
Physicia Viedical Examin	ın/	Decedent's Name (First, Middle,Last)	G	D./I	Lempher			2. Date of Deat	h Day Year	3. Time of Death 0724 hrs	
Vieurcal Examin	iei	Charles 4a. Facility Name (if not institution, give stre	S. et and number)	171	urphy 4	o. City, Town, or Lo	ocation of Dea	December	4c. County of		
. (St. Mary's Hospital				Leonardtown			St. Mary's		
Funeral Director		5. Social Security Number 6. Sex 221-52-2285 1X M		(In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24Hi	_		9. Birthplace (State or Foreign Country)	
ĥ	ŀ	Usual Residence of Decedent 10a. State 10b. County	T	10c. City, To	own or Location	n				10d. Inside City Limits	
Ĕ.,	ō	Md. Talbot			Т	ilghman				1 Yes 2 X No	
the Mary	Director	10e. Street and Number 21486 Willey Road				10f. Zip Code 216	71	10	og. Citizen of What U.S.	•	
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28s-f she traumatic event, the Medical Examiner must be notified at once	y Funeral	1 Never Married 2 Married 1 1 3 Widowed 4 1 Divorced If Ye	s, Give Year	Ver in U.S.	If Ye	Decedent of Hispa s, specify Cuban, I res $2^{\frac{N}{2}}$ No	Mexican, Puert	Specify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White		
36 hin 72 hours a e. than "natura dical Examin	Completed by	15. Decedent's Education (Specify only high Elementary/Secondary (0-12)			during mo	s Usual Occupationst of working life. Caterman			16b. Kind of Busin	•	
21215-0036 uld be filed within 72 he Mental Hygiene. marked other than "un c event, the Medical Ex	Be	17. Father's Name (First, Middle, Last) Charles B. Murphy						e (First, Middle, N June Phi	llips		
e, MD 21 1 and 2 should Health and Me item 27 is ma	ᅀ	19a. Informant's Name/Relationship (Type, I Dawn Turner / Daugh		(0)	19b. Mailing. 110 Ba	Address (Street a	and Number or e. Camb	Rural Route Num ridge, N	ber, City or Town, 10.21613	State, Zip Code)	
2		20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other Specify:	emoval from Stat	_ cre	matory or other	on (Name of ceme or place) e lmarva		Date -23-2011	De lmar,	ity or Town, State DE •	
	d	21. Signature of Funeral Service Licensee	4 C.F.S	.0					Home P. Md. 216		
Physician /Nedical Examiner			ons that caused to e. Hypert plicate				uch as cardiac ic Car	or respiratory arre diovascu	est, shock, or heart lar Disea	Approximate Interval Between Onset and Death	
		or condition resulting in death) Due t Sequentially list conditions, b.	o (or as a consec	quence of):							
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	o (or as a consec								
		d	·								
O, be exected by the control of the	edic			-		Sa-t,per	me,g92	3 1-13-1			
eath ceath contact attention for use		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome Live birth Pregnant at ti		2 Feta	I death 3	Ectopic pregr	ancy	23d. Date of de Month	blivery Day Year	
that the d		Part II. Other significant conditions cont	ributing to death	but not resu	ulting in the un	derlying cause giv	en in Part I.	i	bacco use contribu	te to the cause of death?	
cords, Flaw requires has been sign 2 should be	Completed by	Obesity						24a, Was a autops	an 24b. We	re autopsy findings available or to completion of cause of ath?	
Rec The l	S							1 ✓ Yes 2		Yes 2 No	
Vital Rec hysician: The I this certificate I	o Be	25. Was case referred to medical examiner?	al; 1 Inpatien	t 2 🗸 EF	R/Outpatient	- 0	f Death (Check		Residence 6	Other:	
Division of Vital Records, P.O tal or Attending Physician: The law requires that tre after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detac	-1	1 Natural 5 Pending	8a. Date of Injun (Month, Day,Ye	ar)	8b. Time of Inj		at Work?		ow injury occurred		
Division of V To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	Certification:	2 X Accident Investigation 3 Suicide 6 Could not be determined (Specify) boat 28e. Place of Injury - At home, farm, street, factory, office building, etc. or of								or Rural Route Number, City eake Bay off	
Di To the Hospital within 24 hours . To the Funeral	Medical	29a. Certifier 1 Certifying Physician: T continuous 2 Medical Examiner:On t									
To Your Court	Me	29b. Signature and little of certifier	Vac l	Ino	50	29c, License			29d, Date signed December 2	(Month, Day, Year) 1, 2011	
			eted cause of de ant Medical			Baltimore Str	eet, Baltim	ore, M D 2122	3		
Sta Registi		31. Date filed (Month, Day Year)	32. Registra	s Signature	Kel						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Catherine Marie Newcomer 9:22 2011 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Smithsburg Washington 14237 Edgemont Road 7. Age (In yrs. last birthday) 82 yrs Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 M 2X F Hours OCE 130 1929 MaryTand Director 215-26-8240 Usual Residence of Decedent 10c. City, Town or Location
Smithsburg permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits Funeral Director Washington Md. 1 Yes 2X No 10f. Zip Code 21783 10e. Street and Number 10g. Citizen of What Country? 14237 Edgemont Rd. U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) *Hotel* Manager Be 17. Father's Name (First, Middle, Last)

James R. Reese Sr. 18. Mother's Name (First, Middle, Maiden Surname)
Marie Foreman ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14237 Edgemont Rd. Smithsburg, Md. 21/83 19a. Informant's Name/Relationship (Type, Print) Charles L. Newcomer (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 30, Important: If it any injury or c Dec. . View Cemetery 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Ringgold, Md. Mt. 2011 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 12525 Bradbury Ave. 22. Name and Address of Facility Wis M01414 J.L. Davis Funeral Home Smithsburg, Md. 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underl, in Cause (Disease or iinjury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 month
1 Yes 2 No Month Dav Year Other (specify) cate has been signed by the page 2 should be detached 1 ☐ Yes 2 ₽ 9 ☐ Unknown 9 Linknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 No 25. Was case referred to medical examiner?

1 Yes 2 No funeral director, 26. Place of Death (Check only one) 2 No Hospital: Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural iniury 5 Pending after death. Investigation Accident filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 1 🗴 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 17268 Buchana trail Ecos pac 32. Registrar's ignatu State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ December 2011 03:10A M STEPHANIE NEWMAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S CLINTON SOUTHERN MARYLAND HOSPITAL CENTER Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Months Hours 578-92-2406 Director 1 □ M 2 F Yrs. 10/29/1966 N.I 45 Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland Director 1X Yes 2 No District Heights MD Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 20747 7111 Cross Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ò 1 X Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: "natural", Completed 3 Widowed 4 Divorced **Black** Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Dispatcher Private 12th traumatic event. Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Constance M. Newman Aaron McFadden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) t of Health a: If item 27 is 2019 S. 106 Avenue, Tolleson, AZ 85353 John L. Newman/Brother other 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20b. Place of Disposition (ivarine or cemetery, crematory or other place)

Riverdale Park
Crematory 01/06/2012 1 Burial 2 K Cremation 3 Removal from State injury or Department o Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Riverdale, MD 22. Name and Address of Facility Pope Funeral Homes, P.A. r of Funeral Service Lice Signat 5538 Marlboro Pike, Forestville, MD 20747 01014 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disea shock, or heart failure Approximate Interval Between Onset and Death Immediate Cause (Final/ Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine rche VASCulan Di Sc. burial-transit Cause (Disease or injury that initiated events resulting in death) Last and attending physician for use as the buria nosisofkidu Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year Other (specify) Pregnant at time of death signed by the at Id be detached for 23e. Did tobacco use contribute to the cause of death? Significant conditions, contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 unknown Division of Vital Records, Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy perform 1 ☐ Yes 2 ☐ No certificate Yes 2-25. Was case referred to medical 26. Place of Death (Check only one) funeral director, examiner? Hospital: Other: 2 400 1 Yes 14 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?

1 Yes 28d. Describe how injury occurred injury Natural 5 Pending 2 🗌 No ☐ Accident Investigation filled in by the 24 hours after deal Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cepting Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check within 2. only one 29b. Signature apd f certifie ompleted cause of death (Item 23a) (Type, Print) 30 Name and address of 235 State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2 Date of Death Decedent's Name (First, Middle, Last) Year Month Physician/ 23:35 PM POWELL MHOL ROBERT 201 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Prince Frederick Calvert Calvert Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Sex 1 XM 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Mav14.1933 78 Director 220-28-739 Usual Residence of Decedent show or 28a-f show notified at 10b. County Town or Location 10d. Inside City Limits 10a. State within 72 hours after death with the Maryland Director MD Calvert Huntingtown 1 Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number be USA Funeral "natural", or items 23a 20639 3009 Ponds Wood Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S 11 Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 XNo Specify Specify: Black If Yes Give Completed 3 X Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Menone. Town of Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Chesapeake Beach Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Powel1 E11a Beatrice Robert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 874 Chesapeake Beach, MD 20732 19a. Informant's Name/Relationship (Type, Print) Calvin Gross/Brother P.O. Box 874 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Ernestine JonesCemL1/3/2012 Chesapeake Bch., MD 22. Name and Address of Facility Sewell Funeral Home, P.A. 21. Signature of Funeral Service License Dlady 1451 Dares Beach Rd. Prince Fred., MD2067 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ COMFERT disease or condition SEPSIS Medical resulting in death) WEEK Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician Medical death certificate be P.O. Box 68760 nding p IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery Physician/ 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month for Pregnant at time of death 1 Yes 2 No the a 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Hospital or Attending Physician: The law requires Records, MELLITUS DIMBETES 24b. Were autopsy findings available 24a. Was an HIN prior to completion of cause of death? has page 2 : performed 1 ☐ Yes 2 ☑ No DEMENTIA this certificate 25. Was case referred to medical examiner? **Division of Vital** 26. Place of Death (Check only one) Be Hospital: Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ည 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After work Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death To the Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated wedcal examiners Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0072608 12 27 2011 NShah 1388 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nimit Shown 100 Hospital Road Prince Frederick, mo 20078

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ $\overset{\scriptscriptstyle{\mathrm{Year}}}{\mathrm{2011}}$ 1:30 P^{M} December Brenda Lee Rice Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Frederick Frederick 4319 Dover Drive 8. Date of Birth (Month, Day, Aug 14, Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) Funeral Hours Months 212-64-1274 1954 Maryland 1 □ M 2 🏋 F Director 57 Usual Residence of Decedent items 23a or 28a-f show ier must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State Director 1 Yes 2 X No Frederick Marvland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 4319 Dover Drive 21703 within 72 hours after death v 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. "natural", or 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed r than "natura the Medical F 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working United States life. DO NOT use retired) Elementary/Secondary (0-12) 12 I Hygiene. College (1-4 or 5+) the Federal Government Administrative Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental F is marked o ည Helen Virginia Owens Lovd Lee Dodson Page 1 and 2 should ment of Health and Mr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 James L. Rice, Sr./Husband 4319 Dover Drive, Frederick, Maryland 21703 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) January Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State Resthaven Mem. Gardens 2012 4 ☐ Donation 5 ☐ Other (Specify) 2. Frederick, Maryland of Funeral Service Signati icenses any ir Keeney and Basford PA Funeral Home, 106 E. Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the discase, or complications that caused shock, or heart failure. List only one cause on each line. ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between inset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate
Cause (Disease or injury Due to (or as a consequence of) -transit that initiated events resulting in death) Last Due to (or as a consequence of) use as the burialattending physiciar Physician/Medical spital or Attending Physician: The law requires that the death certificate beours after death.

In the series of the attending physicis in the series of the attending physicis in the funeral director, page 2 should be detached for use as the but the funeral director, page 2 should be detached for use as the but the funeral director. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsv perform Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Yes P 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury 1 X Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral C To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month. Day, Year, 29b. Signature and title 201 6810 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For Amend Item 27 per dr., g. 23,01 Penartment of Health and Mental Hygiene Certificate of Death 42848 Reg. No. 20 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death LFRED SHITH 1,23 PM Month Physician/ December 2011 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner North WEst HOSAI TERL Baltimore Kandallstown Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** (Month, Dav. Year) 231-52-2418 Director 1 🌠 M 2 🗆 F 12/27/1941 70 Virginia Usual Residence of Deced 28a-f show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director must be notified 1 Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? items 23a Funeral APt A 21207 U.S.A. 3051 Essex Rd. death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. 0 þ 1 Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify. Specify: Black "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumasts. the 11th Grade Mail Services Port Authority Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lillie Jane Smith unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3051 Essex Rd. Apt A, Baltimore, MD21207 Jacqueline DuVall-Smith 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1
Burial 2 Cremation 3 Removal from State on-siteCrematory 01/03/11 Baltimore, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses ²ਹਿਲਵਾਸੀਆਂ ਜਿੰ• Prown Jr. 2140 N. Fulton Ave., Funeral Home PA Baltimore, MD21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ DOXEMIZ disease or condition resulting in death) Medical as a consequence of) Examiner StagE Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury that initiated events ician and burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be Box 68760 the use as 1 attending IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Live Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month Day Year 4 Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy nerformed' 1 Yes 2 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospita 2 4 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 욘 ER/Outpatient 3 DOA 1 Inpatient 2 after death. Director: After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide uld not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by 4 Homicide within 24 hours a

To the Funeral C

completely filled To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) D65843 December, 27, 2011

State

31. Date filed (Mou Registrar

Abo

30. Name and address of p

1124

rson who completed cause of death (Item 23a) (Type, Print)

11-09840 John Salkowski

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Rea. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day December 30, 2011 1940 hrs Medical Examiner John Edward Salkowski 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Joppa Harford 911 Rayners Lane If Under 1 Year | If Under 24Hrs | 8, Date of Birth (MM/DD/YYYY) 9, Birthplace (State or Foreign Pennsy I vania 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Director 10/06/1952 200-42-5262 1 X M 2 F 59 Usual Residence of Decedent 10d, Inside City Limits 10c City Town or Location 10a State 10b. County п 1 Yes 2 X No or 28a-f show Marvland Cecil Elkton Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene.

nut: If item 27 is marked other than "natural", or items 23a or 28a-f sho notified at once, rector 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 265 Starkey Lane 21921 United States 14. Race - American Indian, Black, Funera 11 Marital Status 12. Was Decedent Ever in U.S. 13, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 X Married 2 X No Yes 1 Yes 2 X No specify: Yes. Give Year Specify: White 3 Widowed 4 Divorced Š 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) atic event, the Medical **Baltimore**, MD 21215-0036 12 Machinist Steel Manufacturing 18 Mother's Name (First Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Salkowski Anna Kilian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Minerva G. Salkowski/Wife Post Office Box 1909, Elkton, MD 21922-1909 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a, Method of Disposition January crematory or other place) 1 Burial 2 X Cremation 3 Removal from State tant: 2012 R. A. Ferris & Co., Inc. West Chester, PA 4 Donation 5 Other Specify: 22 Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service License 103 W. Stockton Street, Elkton, MD Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. (Madical Death a, Traumatic Asphyxia Immediate Cause (Final disease ≟xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of); Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Ca AMENDED attending physician or use as the burial -UNPENDED To the Hospital or Attending Physician: The law requires that the death certificate be to within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the buria. Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Year Live birth Fetal death Dav 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other Scene 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) FOUND: 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Found partially under tractor FOUND: 1 Natural Pending 1 ✓ Yes 2 No Dec 30, 2011 1939 hrs 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be or Town, State) 911 Rayners Lane, Joppa, MD determined (Specify) Field 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. December 31, 2011 Vav 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) State Registrar

OGME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2:00 A M Sellman F. DECEMBER Mary Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George Lanham Doctors Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthday, **Funeral** Hours 1 🗆 M 2 🏋 Months 6-19-119-12 Maryland Yrs Director 218-24-2925 99 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Maryland Prince George Upper Marlboro 10g. Citizen of What Country? 10e. Street and Number Funeral USA 20772 13303 Old Marlboro Pike Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc 1 Never Married 2 Married þ 3altimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: Black 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry should be filed within 72, and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Mary Ε. Smith James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is 1 Gladys Pinkney/Daughter 13303 Old Marlboro Pike, Upper Marlboro 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Maryland 4 ☐ Donation 5 ☐ Other (Specify) 12/29/11 Clinton 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Adams Funeral Home PA, Aquasco 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CARDIO PUL MONARY disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last vocardia and Due to (or as a consequence of) burialattending physician Physician/Medical certificate be Box 68760 the 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown for t the be detached Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown -umphocytic Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy I or Attending Physician: The after death.

Director: After this certificate by 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗆 Yes 1 🖟 Inpatient 2 □ ER/Outpatient 3 □ DOA Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier The designing in the basis of the basis of examination and/or investigation, in my courred at the time, date and place, and due to the cause(s) and manner stated at Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated at Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D D43446 12-21-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month

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32. Redistrar's Signature

DHMH 17 Rev 7/2009

.D.12150 Annapolis road Suite 200, Glendale MD 20769

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	aryland /		ırtmen <i>tificat</i>			ind M	ental Hy	/giene Reg. No	71111	42	851
	Physici	_	1. Decedent's Name (First, Middle, Last LeRoy William Tay	lor			-				2. Date of D Month Decemb		0, 2011	3. Time 0	of Death O A M
ř	/Medic Examir		4a. Fecility Name (If not institution, give Harrison Senior L				, .	Town.or	Location of	f Death			County of Dea		
	Funeral Director		5. Social Security Number 6. Se 213-22-8703	x 7. Age XM 2□F	84	irthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of B	irth 192	9. Bi	rthplace (State Country) ryland	or Foreign
	Maryland -f show	tor	Usual Residence of Decedent	r	10c. City, Too									10d. Inside (City Limits
	with the	Director	10e. Street and Number 2239 Old Snow Hi	11 Pood			10f. Zip	Code				-	itizen of What C	Country?	
036	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. Is marked other than "natural; or Items 23s or 28s-f show aumatic event, the Modical Exertirer must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 XYes 2 1 If Yes, Give Year or Dates:		"	Vas Dece	dent of Hi	spanic Origin, Mexican	gin? (Spe , Puerto I	cify Yes or N Rican, etc.)		14. Race - Arr Black, Wh Specify: Wh	ite, etc.	
Baltimore, Maryland 21215-0036	d within 72 ho giene. er then "netur . the Madical.	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ication le completed) College (1-4or 5	+)	(Giva	OO NOT u	rk done d	urina most	of workii	ng		Kind of Busines		
and	od a b	To Be C	17. Father's Name (First, Middle, Last) George William Ta	ylor							(First, Midd) Trico	e, Maidei	n Sumame)		
Mary	d 2 should be the and Mental it is marked of traumatic even	F	19a. Informant's Name/Relationship (T Phyllis P. Taylor										or Town, State,	Zip Code) .	1 851 ke, MD
more,	permit. Pages 1 and 2 should Deportment of Health and Mer Important: If Item 27 is marke any injury or other traumatic ance.		20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other (Specify		[ery, cren	natory or c	ther place	1		eate 23/201	1	comoke,		
Baltii	permit. Pag Department Important: any injury o		21. Signature of Funda Service Licens		111130	22	. Name ar	d Addres	s of Facility	у Но	11oway	Fun	eal Hom	e, P.A.	,
1.30	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each lir CENE a	the death. Do	ra) (ACC			arrest,		Approxim Interval B Onset and	etween
3760,	cate be executed by the burial-transit can	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last	b. Due to (or as	a consequence	e of):									
O. Box 68	law requires that the death certificas been signed by the ettending place as bould be detached for use as it.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal deal		Ectopic p Other (sp						23d. Date of d Month	lelivery Day	Year
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Vital Records,	The ete h page	Completed								-	24a. Wa aut per 1 ☐ Yes	opsy formed?	prior t		s available cause of
	ysician is certifi director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatie	ent 2 🗆 ER/0	Outpatien	t 3 🗆 D(Othe			r(<i>Check only</i>		6 □Other (Sp	oecify)	
lon of	ding P h. After ti funera		27. Manner of Death 1 Alatural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ry Yeer) 28b	. Time of Injury	М	28c. Injury Work			28d. Describe				
Division	5 # # C	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inj building, et		farm, str	eet, factor	y, office				(Street a own, Sta	and Number or te)	Rural Route Nu	imber,
	To the Hospital within 24 hours a To the Funeral Completely filled	edical		rsician: To the best iner: On the basis of and manner sta	examination a										9(s)
	To the within To the comp	Me	29b. Signature and Itle of benifier	(ui)					0217			12	ate signed (Mo	nth, Day, Year)	
	ET	2	30. Name and address of person who of SHARAD & SATY	ompleted cause of d	leath (Item 23a (604	MA	Print) NKE	57	Po	CON	NUKE	C	TY M	0 218	51
	Sta Registi		31. Date filed (Month, Day, Year) DEC 2 1 20	32. Registr	eath (Item 23a 1604 ar's Signature	400	enter	•							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death December Day Physician/ Christine Tabbs Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Regional aure Hospita Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 □ M 2 F Months Days Hours Min. (Month, Day, Ye Washington, DC 74 577-50-7766 Director 1937 Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Maryland Prince George's Laure1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7101 Fitzpatrick Drive 20707 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. African Armed Forces? 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes Give American "natural", 3X Widowed 4 ☐ Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) 12 years College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other that Government Program Manager Be other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Willeen Reed Dewey Strong 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 16 Brighton Place Woolwich Township, NJ 08085 Johann Sharp - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🛮 Burial 2 🗌 Cremation 3 🗎 Removal from State injury or Harmony Mem. Park Dec 30, 2011 Landover, MD 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility Stewart Funeral Home, Inc. Signature Funeral Service Licensee Benning Road, NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner idbetic quentially list conditions. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Renal Acute The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Dav 5 Other (specify) Pregnant at time of death signed by the a Id be detached f 1 ☐ Yes ∠ y 9 ☐ Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Records, Completed neec 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I performed? 1 Yes 2 No • Hospital or Attending Physician: The 24 hours after death. • Funeral Director; After this certificate 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 🗌 Yes 2 X No 1 inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No Natural 5 Pending injury Accident Investigation filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician; To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifie 29d. Date signed (Month, 2011 700 7300 Van Dusen Road who completed cause of death (Item 23a) (Type, Print) Regional Hospital aure State DEC 2 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 42853 State of Maryland / Department of Health and Mental Hygiene 2 \(\begin{align*} 1 \\ 1 \end{align*} For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 1 2 Physician/ A^{M} Trader 6:30 2011 Lee 18 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico Salisbury Atria Assisted Living 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F Months Days Hours Min. 11-2-1926 85 Maryland Director 222-12-2395 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland Director Page 1 and 2 should be filed within 72 hours after death with the Marylar ment of Health and Mental Hygiens are fined to the them 23a or 28a-f si lant. If item 27 is marked other than "natural", or items 23a or 28a-f si ury or other traumatic event, the Medical Examiner must be notified. 1 Yes 2 X No Salisbury MD Wicomico 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral USA 21804 209 Morris Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Force Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 X No Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates. 1 ☐ Yes 2 🔀 No Specify: 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Education Teacher 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Stagg Butler Katie Charles Ρ. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryland 21804 209 Morris Drive, Salisbury, <u> Sherri Hynes - Daughter</u> 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of I
Important: If ite
any injury or ot cemetery, crematory or other place) 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Springhill Memory Gd. 12-23-2011 Hebron, Maryland 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Funeral Service 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Medical Examiner Due to (of consequence of): Sequentially list conditions, if any leading to mind a cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnent in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for Month Day Year Pregnant at time of death ned by the a 9 Unknown s been signed to should be deta Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsv 2 No 1 Yes Yes Division of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 - No 1 🗆 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di this 28a. Date of injury (Month, Day, Year) 27. Manne Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending Natural Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined building, etc. (Specify) City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License numbe SIE apdress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and レマソ egistrar's Signature Year) 0 State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 4:35 PM Physician/ Thomas Francis Wright, Sr. DECEMBER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE TOWSON SHINT JOSEPH MEDICAL CENTER If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, Year) Hours 85 219-20-2016 **1X** M 2 □ F **Director** Maryland June 20, 1926 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director Yes 2 No Hanover York PA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 17331 91 South Street death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 XYes 2 No Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White If Yes, Give WWII 3 Widowed 4 Divorced Year or Dates. the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Silver Run Rental Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Storage Trailers Owner/Operator d 2 should be filed with alth and Mental Hygien 27 is marked other t Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Nickoles ပ Leo Crobitt other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 91 South St., Hanover, PA 17331 Carol Ann Miller Wright/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cremation Inc 12/31/2011 Hampstead, Maryland Pritts Aftrefally Home and Chapel, P.A. 21. Signature of Funeral Service Licensee The 412 Washington Rd., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last the burial-trar and Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be Box 68760 use as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year ed by the at detached f 9 Unknown P.O. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ARTERY To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) completely filled in by the funeral director, 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 X Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 🗶 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: injury 1 X Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gertifying Nurse Prachitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Prachitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of cer 46356 of person who completed cause of death (Item 23a) (Type, Print)

State Registrar m.D.

7601 OSLER DRIVE

TOWSON MARYLAND

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Amend Items 15,23e per fh/dr, g925,03/02/2012dhb

For Amend Item 5 per inf ngway 2002/08/2012dhb Health and Mental Hygiene

1 - State Registrar

Certificate of Doction 42855 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Leo1a Williams Dec 16^{ay} 2011 10:46A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takcoma Park Montgomery If Under 1 Year I If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🗆 F Months Days Hours (Month, Day, Year, **Director** 9 1916 South Carolina 95 Apr Usual Residence of Decedent 28a-f show D . C . 10d. Inside City Limits 10b. County 10c. City, Town or Location Washington or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 No 10f. Zip Cod 20019 10g. Citizen of What Country? 10e Street, Eads Street, N.E. Funeral U.S.A. · death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc.
Black 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: Completed 3

Widowed 4 □ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 tal Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Factory Worker Private 8th permit, Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Albert Shannon Bertha Jaggers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alonzo Williams, son 6006 Eads Street NE, Washington D.C. Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State Glenwood Cemetery 12/28/201 Washington, D.C 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hall Brothers Funeral Home 21. Signature Juneral Service Licensee 621 Florida Avenue NW, Wash. D.C. ne 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Kappy Immediate Cause (Final 12154456 Physician. disease or condition Medical resulting in death) Que to (or as a consequence of) **Examiner** NEUMONIA Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Examine OSTRIBIUM DIFFICILL Cause (Disease or injury Hospital or Attending Physician; The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as inding use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ğ Month Day 5 Other (specify) signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 X No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an this certificate has ral director, page 2 autopsy Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1.X Yes 2 No 2 1 Inpatient 2 KER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After tompletely filled in by the funer injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1. 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2011 D 044957 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Randall Wagner 7600 Carroll Avenue, Takcoma Park, Maryland 20912 31. Date filed (Month, Day, Year) DEC 2 8 2011 32. Registrar's Signatu State Registrar

11-09627 Pannia Daga Ad	ame	Please Type or Print in Bl						gible.	
Ronnie Dean Ad		State of Maryland . 1- For State		cate of L		a went		20	11 4285
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)		3410 07 2			2. Date of Dea		3. Time of Death
Medical Exami		Ronnie Dean Adams					Month Decembe	Day Year r 23, 2011	0556 hrs
		4a. Facility Name (if not institution, give street and number) Peninsula Regional Medical Center			City, Town, or Salisbury	Location of	Death	4c. County of Di Wicomico	eath
Funeral		5. Social Security Number 6. Sex 7. Ag	e (In yrs. last bi	irthday)	If Under 1 Yea			rth (MM/DD/YYYY) 9.	Birthplace (State or or oreign
Director		214-68-7076 1XM 2 F Usual Residence of Decedent	51	Yrs.	Months Day	s Hours	Min. 08/23,		Delaware
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	BeC	Grover Cleveland Adams Jr	•				lla Virgin		rđ
	5	19a. Informant's Name/Relationship (Type, Print) Steven M. Culver/partner	15				per or Rural Route Nur ane, Salish		
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x 687 th certification that the second in grand in grand in grand in use as the second in grand in use as the second in grand in use as the second in grand	ciar	past 12 months?	diam and almosts	- =	death 3 (Specify)	Ectopic	pregnancy	Month	Day real
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Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physici inpitetly filled in by the funeral director, page 2 should be detached for use as the burn.		Part II. Other significant conditions contributing to death Liver Cirrhosis	but not resultii	ng in the und	lerlying cause (given in Par			e to the cause of death? Probably 4 Unknown
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Division soptial or Attent hours after death net Director: y filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify)	ury - At nome,	rarm, street,	тастогу, опісе в	oullaing, etc.	or Town, S		r Kurai Route Number, City
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To the within To the comple	Medical	one) 2 Medical Examiner: On the basis of examiner and manner stated. 29b. Signature and title of certifier	/	Jongulo	29c. Licens			29d. Date signed	
	-	61	A		O.C.			December 24	
		30. Name and address of person who completed cause of d	eath (Item 23a)	_ <					
		Zabiullah Ali, M.D. Assistant Medical Ex	aminer 9	00 W. Ba	timore Stre	et, Baltin	nore, MD 21223		
St Regist	ate	31. Date filed (Month, Day, Year) 33. Registra	's Signature	haisto	1				
A1-35 [F]		WENT TOTAL	- A-2 - K	ALE VIEW					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2215 M 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center <u>Annapolis</u> <u> Arundel</u> If Under 1 Year If Under Months | Days | Hours Birthplace (State or Foreign Country) 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) 578-22-4080 Director 1 🛛 M 2 🗆 F 04/25/1923 Washington DC 88 show 10c. City. Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland and Mental Hygiene. Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 Yes 2X No MD Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21114 USA 1507 Marlborough Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Repair/Install Telephone Systems Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert McCullough Ashlin Helen Varney Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1466 Blockton Court Crofton, MD 21114 John S. Ashlin 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place)
Atlantic Crematory 12/18/2011 Glen Burnie,MD 4 Donation 5 Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility 851 Annapolis Road Gambrills,MD 21054 Oats Hardesty Funeral Home P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury Due to for as a nor securing of Examin Hospital or Attending Physician: The law requires that the death certificate be executed g physician and as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ģ Month Day Year Pregnant at time of death 5 Other (specify) Yes i signed by the at Id be detached f Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 3 Probably 4 Unknown been sig should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed' 1 Yes 2 No certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 5 Pending injury Natural 2 Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier Cavanagh cause of death (Item 23a) (Type, Print) George 30. Name and address of person who complete 32. Re istrar's Signature State DEC 2 0 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 50A Helen M. Ahalt 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Airv Kline Hospice House Mt. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/4/1920 Birthplace (State or Foreign Country)
 MD Social Security Number 7. Age (In yrs. last birthday Days Hours 219-44-3971 1 - M 2 - F 91 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 XYes 2 No Jefferson Frederick 10e. Street and Number 10g. Citizen of What Country? 3812 Jefferson Pike 21755 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify. White If Yes Give 3 ₩ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) own home homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis George Morrison Marchie Cordell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Ahalt Sr. (Son) 3641 Jefferson Pike, Jefferson, MD 21755

Department of Important: If any injury or once, Physician Medical Examiner

Physician/

Medical

10a. State

MD

Director

Funeral

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Completed

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Examiner

Funeral

Director

28a-f show

items 23a or 28a-f shoner must be notified at

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

nt of Health and Mental Hygiene.

It item 27 is marked other than "natural", or iter
or other traumatic event, the Medical Examiner

burial-tran attending physician for use as the burial been signed by the should be detached page 2 s certificate has After this within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

	1 🔀 Burial 2 🗆 Cremation 3 🗆 Remo	oval from State cemeter)	y, crematory or other place)		20c. Location - City or	
	Donation 5 Other (Specify)	Refo	rmed Cemeter			
	21 Son ture of Fune Service Like see	+		Amompson Fun Idletown, MD		2
	23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one tay immodiate gause (Final disease in condition resulting in death)	hs that caused the death. Do not see on each line. THETUS CLETT. Due to (or as a consequence o	USIF COMONIM			Approximate Interval Between Onset and Death
al Examiner	Sequentially list conditions, large	Due to (or as a consequence of				
Completed by Physician/Medical Examiner	in the past 12 months?	f yes, outcome of pregnancy Live Birth 2 Petal death Pregnant at time of death Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of del Month	ivery Day Year
ed by Ph	Part II. Other significant conditions contribu	iting to death but not resulting in	n the underlying cause given in		bacco use contribute to	the cause of death?
Sompleto				24a. Was a autop: perfor 1 \(\square\) Yes	sv prior to	topsy findings available completion of cause of
Be (25. Was case referred to medical examiner?		26. Place of	Death (Check only one)	307	53
To	1 🗆 Yes 2 💢 No	tal: 1 ☐ Inpatient 2 ☐ ER/Ou	ntpatient 3 DOA Other: 4 [☐ Nursing Home 5 ☐ Reside	ence 6 XOther (Spec	ify) Hospice-
ficate:	1 Natural 5 Pending 2 Accident Investigation		ime of njury at work? M 28c. Injury at work? 1 \sqrt{Yes}		ow injury occurred	
Medical Certificate:	4 - Homicide determined	8e. Place of Injury - At home, far building, etc. (Specify)		City or Town		
Medica	(Check 2 Medical Examiner: Conly one) 3 Certifying Nurse Pra	: To the best of my knowledge, on the basis of examination and/or actitioner: To the best of my know	or investigation, in my opinion, dea	ath occurred at the time, date ar	nd place, and due to the	cause(s) and manner state
	29b. Signature and title of certifier		29c. License num	ber 2	29d. Date signed (Monti	4 .
	11111	W 1	1 1 1	1 6 1	1/-/	/ /

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State Registrar 31. Date filed (Month, Day, Year)

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Toll House

MED EMICK

and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

KAZMI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Źΰ, 2011 0130 December 0wen Brubaker Wayne Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Casey House - Montgomery Hospice Rockville Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year, 579-20-2802 Director 1 X M 2 □ F 87 NOV 14, 1924 KS Usual Residence of Decede or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County with the Maryland rector 1 X Yes 2 No MD Gaithersburg Montgomery ö 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? ms 23a or must be n Funeral 20877 United States 401 Russell Avenue #611 · death v 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status ian "natural", or ite Medical Examiner rmed Forces?
X Yes 2 \sum No 1943-If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 X Married þ 1 ☐ Yes 2 👿 No Specify: 1945 Specify: Caucasian 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Trade Associations Executive other Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked c ည Brubaker Margaret Lavern 0wens William Lafayette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau 401 Russell Avenue, #611, Gaithersburg, MD 20877 Joan H. Brubaker / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 12/23/2011 Brentwood, MD 2. Name and Address of Facility Thibadeau Mortuary Service, p.a. 21. Signature of Funeral Service Licenses Muc M00956 Park Avenue, Gaithersburg, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition BLADDER CANCER Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transif Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buris Physician/Medical IF FEMALE: f yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L Fetal deal Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) signed by þ To Be Completed has

The law requires that the death certificate be P.O. Box 68760 Division of Vital Records, this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific filled in by the

Baltimore, Maryland 21215-0036

9 Unknown	9 🗍 Unknown	
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※☐ Unknown
		24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
25. Was case referred to medical	26. Place of Death (Check of	nly one)
examiner?	Hospital: 1	e 5 Residence 6X Other (Specify) HOSPICE
27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident Investigat	28a. Date of injury (Month, Day, Year) 28b. Time of injury work? on M 1 Yes 2 No	d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	1 286 Place of Injury - At name farm street factory affice	ff. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying P	nysician: To the best of my knowledge, death occurred at the time, date and place, and	due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year)

R143201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6001 MUNCASTER MILL ROAD, ROCKVILLE, MD 20855 DEBORAH MILLER, CRNP,

State Registrar

Certificate:

Medical

31. Date filed (Month, Day, Year,

DEC 22 2011

Registrar's Signat

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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. Amend 24a per med cert 6923 1717/12 dk State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 21:16 M +2 a 25-2011 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Peninsula Regional 6. Sex Salistury
Hadar 1 Year | If Under 24 Hrs. Medical Center Wicomico Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 M 2 YF Days Director 230-48-1305 12-31-1939 Usual Residence of Decedent la or 28a-f show t be notified at 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 Yes 2 No Director Nelsonia HCCOMack 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with innent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or? 23414 U.S.H ral", or items 23a Examiner must b ankford Highway 7405 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Specify: 3 ☐ Widowed 4 MDivorced "natural", other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Driver Chincotague Senior Gr. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be seorge Ellint ျှ Willie Hastings

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willie 19a. Informant's Name/Relationship (Type. Print) Chincoteague, VA a3336

Date | 20c. Socation - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Fitchett Daughter Mitzi 20a. Method of Disposition Important: If it any Injury or c 1 ☑Burial 2 ☐Cremation 3 ☐Removal from State ille Cemetery 12-29-2011 22. Name and Address of Facility Wattsville, UA 4 ☐ Donation 5 ☐ Other (Specify) Wattsville 21. Signature of Funeral Service Licenses Chincoleoque, UA 23336 Salver Home, Inc. tuneral 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) televisio **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Day to (or as a consequency of): Examiner sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. I 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director page. 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ို 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 12-27-2011 R. BARALIN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

NY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 42861 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ recember 23 2011 Medical 4b. City, Town, or Location of Death Examiner Facility Name (if not institution, give street and number 4c. County of Death Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours 230-50-4106 Director 1 🗆 M 2 🗶 F Yrs 71 09/10/1940 Virginia or 28a-f show 10b. Count 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6118 Steve St. 21804 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Stock Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Warren Brown Mamie Turlington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6118 Steve St., Salisbury, MD 21804 Donald Beach/Husband Department of Health Important: If item 27 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pollitt's Cemetery 12/28/2011 Salisbury, MD Signature of Funeral Service Licensee HolToway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ lymphoxylic leukemis large granular disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of that the death certificate be executed burial-trai that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? <u>}</u> or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 performe 2 No 1 Yes 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending work 1 Yes 2 No Accident Investigation Could not be filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie RE5-000 LITE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North Wolfestreet Bultimore. Litrak, MD 600

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day,

Box 68760

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Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December Day 7 1:15 p 2011 Margaret Elizabeth Barnes Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Denton Caroline Homestead Manor 9. Birthplace (State or Foreign If Under 8. Date of Birth Social Security Number Year If Under 24 Hrs. 7. Age (In yrs, last birthday) Funeral Days Sept. 20,1914 Pennsylvania 1 🗆 M 2 🛣 F Months Hours Min. 97 Yrs Director 218-34-7786 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. In the Maryland should be so that If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at Director Rhodesdale MD Dorchester 1 ☐ Yes 2 🏝 No 10e. Street and Number 10f, Zip Code 10q. Citizen of What Country? Funeral 21659 USA 5470 Cokesbury Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Force Black, White, etc 1 Never Married 2 Married Completed by 1 Yes 2 X No Maryland 21215-0036 white 1 Yes 2 No Specify: 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (3-4 or 5+) registered nurse hospital Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Henrietta Gengnagel Theodore F. Fischer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5470 Cokesbury Road, Rhodesdale, MD Paul N. Barnes son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. Commetery, crematory or other place)
Maryland Veterans Cem. 12/22/11 1 K Burial 2 Cremation 3 Removal from State Hurlock, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final end dementia Physician/ 94aa disease or condition Medica resulting in death) ^{*}Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours are reteath.

To the Funeral Director: Afrer this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE nse yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available 24a. Was an autopsy performed Yes 2 prior to completion of cause of death? 1 Yes 2 🗌 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Assisted Other: 4 Nursing Home 5 Residence 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 🗹 Natural (Month, Day, Year) 5 Pending work?
1 Yes 2 No ☐ Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number WD 00053255 2011

Registrar
DHMH 17 Rev 7/2009

State

melmda
31. Date filed (Month, Day, Year)

DEC 20

3683 Chapterk

82. Registrar's Signature

Frest 9

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Marguerite Butler 12:50 р м December 16, 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick Emmitsburg St. Joseph's Ministries Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🗙 F Months New York 84 Hours Nov 28, Year 927 122-20-3632 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director Emmitsburg Maryland Frederick 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21727 Funeral 335 South Seton Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 ☐ Yes 2 No Specify: If Yes, Give Specify: white 3 Divorced Year or Dates or other traumatic event, the Medical 16b. Kind of Business Industry
Religious Community 15. Decedent's Education 16a. Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event" (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Daughters of Charity Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Edmund Butler Marquerite Klauberg 19a. Informant's Name/Relationship (Type, Print) Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 333 So Seton Ave, Emmitsburg, MD 21727 Mary Xavier McKenna, Servant 20a. Method of Disposition 0b. Place of Disposition (Name of Scenetal Science Sc 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Emmitsburg, MD 12/20/2011 Provincial House 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Myers—Durboraw Funeral Home 210 W Main St, Emmitsburg, MD 21727 Approximate Interval Between 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. set and Death Immediate Cause (Final Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician. The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 9 Unknow art II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan performe 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 1 No 잍 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work ___atural 5 Pending 1 🔲 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by ☐ Homicide determined To the Hospital or within 24 hours a To the Funeral D Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. WJL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - PORTIER 121-123 W. MAIN EMMITSBURG, MD. 21727 ST. KREMPEL BON 1+4 J. 31. Date filed (Month, Day, Year, Redistrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Herbert Lyman Bigelow Jr. 11:10 AM December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington Meritus Medical Center Hagerstown 9. Birthplace (State or Foreign Country) Iowa 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 526-05-8380 Hours Feb. 14, 1916 **Director** Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. That: If item 27 is marked other than "natural", or items 23a or 28a-f sho that: If item 27 is marked other than "natural", or items be notified at jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Keedysville Md. Washington 1 Yes 2X No 10f. Zip Code 21756 10e. Street and Number 10g. Citizen of What Country? Funeral 5810 Mt. Briar Rd. U.S.A 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Completed by 1 Never Married 2 Married 1X Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: Specify. 3 🗆 Widowed 4 🗆 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Electronics Eng. 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Naval Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Gertrude Kramer Herbert L. Bigelow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 5810 Mt. Briar Rd. Keedysville, Md. 21756 Sharon Draper (Daughter) Department of Health Important; If item 27 any injury or other tronce. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dec. Date 1, cemetery, crematory or other place)
Smithsburg Crematory 1 Burial 2X Cremation 3 Removal from State Smithsburg, Md. 2011 4 Donation 5 Other (Specify) 12525 Bradbury Ave. Signature of Funeral Service License 22. Name and Address of Facility J.L. Davis Funeral Home Smithsburg, Md. 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ welke disease or condition Medical resulting in death) **Examiner** week Sequentially list conditions, Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? yes 2 □ No 9 Unknown 9 Unknown this certificate has been signed by rail director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Entero colitis 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 27 No Hospital Other: မ 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: Natural 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After (Month, Day, Year) injury work? 5 Pending ☐ Accident Investigation 3 Suicide 4 Homicide Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, determined filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Malik

DHMH 17 Rev 7/2009

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MD 32. Registrar's Signature Lappans Rd Boonsboro MD 21713

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of IVI	aryland		artment of H tificate of D		vientai Hy	giene Reg. No.	201	1	42865	
H	Physicia	n/	1. Decedent's Name (First, Middle,	Last)					2. Date of De	eath Day	Yea	ar	3. Time of Death	
	Medic	al	Frederick Ma		er				12.	- 22	126 -	1	1:17 AM	
	Examin	er	4a. Facility Name (if not institution, g		٠ ١ .	V e	4b. City, Town, or Salis		1	4c. County of Death Wicomico				
year)	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.							th	9. Birthplace (State or Foreign			
	Director		548-42-4727	1 X M 2 □ F	79	Yrs.	Months Days	Hours Min.	7/10/	1932	2	Countr	CA	
	show at	ď	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Loc	ation					10	0d. Inside City Limits	
	Maryla 18a-f	Funeral Director	MD Worc	ester	Ber	lin							1 ☐ Yes 2 🙀No	
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' O	or iter	by Fu	11. Marital Status1 ☐ Never Married 2 ☐ Marrie	12. Was Decedent E Armed Forces? 1 \(\sum \) Yes 2 \(\overline{\text{K}}\)		13. V	Vas Decedent of His Yes, specify Cuban	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	1	 Race - A Black, W 			
036	rs afte Iral", Exan	ed b	3 Widowed 4 Divorced	If Yes, Give Year or Dates.		1	☐ Yes 2X No	Specify:		s	Specify: W	hi.	te	
5-0	2 hou "natu edical	plet	15. Decedent (Specify only highes		1	(Give I	lent's Usual Occupa	tion uring most of wor	king	16b. Kin	nd of Busine	ess Indi	ustry	
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ylar	id be f Menta arked atic ev	잍	Wilmer Paul	Bruner				Mario	n Alic	e Ma	rtin			
Mar	shoul and is m		19a. Informant's Name/Relationship		114		g Address (Street a					,		
e, N	and 2 Health em 27 ther t		Theresa Gumm 20a. Method of Disposition	Bruner /	Wife		519 Cal	vin Lan			MD cation - City			
nor	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 ☒ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp		cem	etery, cren	natory or other place		Date		,		,	
Baltimore, Maryland 21215-0036	mit. P. sartme sortan vinjur.		21. Signature of Funeral Service Lice		FILS		ate Cres		23/11 rhage		lsbo			
ä	Deg any		Dem 1	Macho	ack		108 Wil:	liam St	., Ber	lin,				
			23a. Part 1 Enter the disease, or conshock, or heart failure. List on	ly one cause on each line	t.				or respiratory ar	rest,			Approximate Interval Between	
~	hysician/ Medical		Immediate Cause (Final disease or condition resulting in death) Onset and Death Due to (or as a consequence of):											
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		iner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequen	ce of):						1		
	cuted nd ransit	Examiner	Cause (Disease or iinjury that initiated events c											
	icate be executed physician and s the burial-transit	alE	resulting in death) Last	Due to (or as a	a consequen	ce of):								
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98	certifi anding use as	M/m	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome] ====================================			2	3d. Date of	delive	ry	
Box	death	Physician/M	in the past 12 months? 1 Yes 2 No	4 Pregnant a			Ectopic pregnancy Other (specify)	/			Month	[Day Year	
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⋛	Physic this ce al dire	မ	1 Yes V No		ent 2 ER			4 ☐ Nursing H	ome 5 Resi			pecify)	Hospieak	
n 0	ding Fig.	Certificate:	27. Manner of Death Natural 5 Pending 2 Accident Investiga	28a. Date of injur (Month, Day		b. Time of injury	28c. Injury work? M 1 🗆 N	at Yes 2□No	28d. Describe l	how injury	occurred		the law	
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within E4 Hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical Ex	Physician: To the best of aminer: On the basis of each	kamination an	id/or invest	igation, in my opinior	n, death occurred a	at the time, date	and place, a	and due to th	he caus	se(s) and manner stated.	
	To the within to the comple	Σ	only one) 3 \square Certifying 29b. Signature and title of certifier	lurse Practioner: To the	best of my kn	iowledge, d	29c. License	number	ace, and due to th		and manner signed (Mo			
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P	n 5		30, Name and address of person w	no completed cause of d	eath (Item 23 2kV SH	a) (Type, P	DR, SAL	SBURY, P	10, 218	4.				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42866 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER 2011 MILLARD TYDINGS BOTT 07:06 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death UNION HOSPITAL OF CECIL COUNTY ELKTON CECIL 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 🕅 M 2 🗆 F Hours MARCH 14, 1941 PENNSYLVANIA Director 217-36-3578 70 Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location should be filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Director 1X Yes 2 ☐ No MARYLAND CECIL CHARLESTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ural", or items 23a c I Examiner must be Funeral 216 CAROLINE STREET 21914 UNITED STATES 12. Was Decedent Ever in U Armed Forces? A T 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian AIR Completed by 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Maryland 21215-0036 If Yes, Give Year or Dates. 1960–66 1 ☐ Yes 2 X No Specify. Specify: WHITE 3 Widowed 4 X Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) AUTOMOTIVE Elementary/Seconday (0-12) College (1-4 or 5+) ASSEMBLER MANUFACTURING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JESSE JOHNSON BOTT MARY JANE ROBINSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BETTY WALSH / COMPANION 5 SUMPTER LANE, ELKTON, MARYLAND Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State DECEMBER. 1XXBurial 2 Cremation 3 Removal from State CHARLESTOWN CEMETERY : 27, 2011 Donation 5 Other (Specify) CHARLESTOWN, MARYLAND 21. Signatur of Eune Service are e 22. Name and Address of Facility CROUCH FUNERAL HOME, P.A. 127 SOUTH MAIN STREET, NORTH EAST, MARYLAND21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final ISCHEMIC CARDIOMYOPATHY Pnysician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner RENAL DISEASE STAGE Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Yes 2 No ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform certificate completed filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🖪 No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending 1 Natural 2 Accident
3 Suicide Investigation s after death 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated D 63486 MD DECEMBER, 27, 2011

Registrar

State

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STREET, ELKTON,

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Year

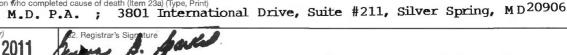
29d. Date signed (Month, Day, Year)

December 20, 2011

of Vital Division

> State Registrar

Nakul Gdyal, 31. Date filed (Month, Day, Year **DEC 21 2011**



erson who completed cause of death (Item 23a) (Type, Print)

D38457

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December Physician/ MASII eline 31 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** County General Hopital Columbia go ward 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours 200-22-9982 85 **Director** 1 □ M 2 🕱 F 3/2/1926 Pa Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland notified at Director 1 Yes 2 ☐ No Elkridge MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 6901 Scarlet Oak Drive 21075 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗶 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: white "natural" 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Ida Feister Ernest L. Pee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula Martin daughter 54 Clover Lane, PO Box 201, Lively, VA 22507 Baltimore, 20c. Location - City or Town, State 19406 20b. Place of Disposition (Name of cemetery, crematory or other place) Pa 20a. Method of Disposition Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Cremation Society of 1/6/2012 King of Prussia, Pa 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility Auer Cremation Suces of Pa., Inc. 4100 Jonestown Road, Harrisburg, Pa 17109 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ulmonas Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 month Month Day Pregnant at time of death 5 Other (specify) g 🗌 Unknown be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Yes Completed page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No autopsy performed certificate Yes 2 filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 2 200 1 Inpatient 2 R/Outpatient 3 DOA မ 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Hatural 5 Pending after death. Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completely filled Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and the 29d. Date signed (Month, Day, Year) mpleted cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year,

21045

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011 42869 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ December 20, 2011 Mervin Aaron CONN 12:25 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery National Lutheran Home Rockville If Under 1 Year If Under 24 Hrs Months Days Hours Min. Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Month, Day Year) 1920 Washington, DC **Director** 91 579-12-5211 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 ☐ Yes 2 🔽 No Maryland Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? United States 20910 1015 Noyes Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc ģ 1 Never Married 2 Married Maryland 21215-0036 white 1 Yes 2 XNo Specify permit. Page 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; If Yes Give 3 ¥ Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Musician Music Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marie Pinnon Harry Cohen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1015 Noyes Dr., Silver Spring, MD 20910 Robert Conn, Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 N Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mt. Lebanon Cemetery 12/22/11 Adelphi, MD Signature of Funera TorchThsky Hebrew Funeral Home 254 Carroll St. NW. Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PROSTATE Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed Sician and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 L Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 🗷 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 2 🖳 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA funeral (27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 🔀 Natural 5 Pending work 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Box 68760 P.O. To the Hospital or Attending Physician: The law requires Records, Division of Vital within 24 hours after death. To the Funeral Director: A 4 completed

> State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

AWTHO MY

31. Date filed (Month, Day, Year) 22 DEC

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



9700

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0051158

, ROCKVILLE

DECENBER, 20, 2011

40 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 42870 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 18,2011 Physician/ Ruth S. Colker 7:52 am Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3118 Gracefield Road, #523 Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 216-46-4364 **Director** 1 🗆 M 2 🗶 F 93 March 05.1918 Pennsylvania Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Silver Spring 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3118 Gracefield Road. 20904 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc. 1 Yes 2 X No If Yes, Give Year or Dates. ō þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural" Completed 3 XWidowed 4 Divorced White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ည Isidore Shechtman Anna Shechtman permit. Page 1 and 2 should be Department of Health and Men Important: If Item 27 is marke any injury or other traumatic traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Danoff - Daughter 338 Los Alamos Road, Santa Rosa, California 95409 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗶 Burial 2 🗆 Cremation 3 🗆 Removal from State Judean Mem. Grdns. 12/20/2011 Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Hines-Rinaldi Funeral Home, MO1524 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner <u>Cerebrovascular Accident</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of and in the standard Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 Yes 2 No Medical Certificate: 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) D0036716 December 19, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

Andrew Kundrat.

DEC 22 2011

31. Date filed (Month, Day, Year)

M.D..

P.O.

3110 Gracefield Road, Silver Spring, Maryland 20904

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Examin	er	4a. Facility Name (if Union		i, give street and nu ial Hospi				4b. City,		Location 1			40	c. Count	y of Deat	:h	
Funeral		5. Social Security N	umber	6. Sex 1 M 2 X F			ast birthday)	If Unde Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Nov . 21	rth ay, Year)	0.7	9. Bir Ço	untral	State or Foreign
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Seconday (0-12) College (1-4				(Give kind of work done during most life. DO NOT use retired) Office Worker							Baking Company				
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2 sho Ith and 27 is r		19a. Informant's Name/Relationship (<i>Type, Print</i>) Mary Kinnikin (Daugh			, in the state of			E. Gr				a <i>i Houte Numbi</i> Delmar,		ty or Town, State, Zip Code) 19940			
1 and of Hea item other		20a. Method of Disp	position			20b. F	lace of Disp	position (Narematory or o	ne of			Date	1			Town, St	ate
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permit. Departimont Import any inj		21. Signature of Fu	neral Service	Licensee				22. Name ar Shor					-		\T 1	10010	
		23a. Part 1. Enter t	the disease, o	r complications that	t caused	the deat	h. Do not er					ceet Do		r, I)E		oximate
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Medical Examiner		resulting in death)		Due to	or as	a conseq	ence of):										
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the at	Completed by Physician/Medica	1 Yes 2 9	XNo	egnant a known	t at time of death 5 🗌 Other (specify)n							Month Day Year					
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quires en sig ould be	ted t											1 🗆	Yes 2	2 🔀 No	3 🗆 P	robably	4 Unknown
law re has be e 2 sh	mple											24a. Was	s an opsy formed?	24b			dings available on of cause of
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uttendi death. ctor: A y the fu	Certificate:	2 Accident 3 Suicide	Invest 6 Could	not be	e of Ini	ırv - At ho	me farm s	M treet, factor		Yes 2L	J No	28f. Location	(Street a	nd Num	her or Ru	ıral Route	Number
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the bure.	Medical	(Check 2 only one) 3	Medical Certifyin	g Physician: To the Examiner: On the b g Nurse Practione	asis of e	xaminatio	n and/or inve	estigation, in	my opinic	on, death o	occurred a	at the time, date	and plac	e, and d	ue to the	cause(s) a	and manner stated.
To t		29b. Signature and	title of certifie		D.				29c. License number AT 2438946 Print) vay. Balâmore, MD, 21218				29d. Date signed (Month, Day, Year)				
SE		30. Name and addr	_	who completed ca	use of d	eath (Item	1 23a) (Type	, Print)	1-	.,_	10 -	1218					
<i></i>		NING 31. Date filed (Mont	JIN the Day, Yeard	20 East	Registra	uersita ar's Signa	y Yark	way. Bi	attum	ore, N	1V, Z	1218					
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DHMH 17 Rev 7/2009

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		_1	For State Amend 28a-28 Pog 1/4/2012 1. Decedent's Name (First, Middle, Last)	f per ME,	Cei	tificate of L	Death		leg. No. 2 (42873
	Physicia	n/	1. Decedent's Name (First, Middle, Last) Adam Christo	1 / .				2. Date of Deat Month	Dav	Year	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give str	eet and number)	,		Location of Death	,,,,,	4c. County		tec
- And the second	Funeral		300 Crusader Rd 5. Social Security Number 6. Sex	7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	1		ace (State or Foreign
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the Mis	t or 28a	Funeral Director	10e. Street and Number		<u> </u>	10f. Zip Code			10g. Citizen of V		try?
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15-0036 OUT	"natural", or items 23a or 28a-f show edical Examiner must be notified at	ρ	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	 Was Decedent Ever in Armed Forces? Yes 2 ☑ No If Yes, Give Year or Dates. 		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No		Rican, etc.)		e - America k, White, e	
21215-0036 within 72 hours after	f Health and Mental Hygiene. item 27 is marked other than "natu other traumatic event, the Medical	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give	dent's Usual Occup kind of work done of O NOT use retired)	ation during most of work	ing	16b. Kind of Bu		
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Maryland	n and Mental Hygiene. I is marked other than "r raumatic event, the Med		19a. Informant's Name/Relationship (Type	, Print)	19b. Maili	ng Address (Street				tate, Zip C	ode)
2	f Health a item 27 i other tra		Justine Jones	/mother		Crusader					
Baltimore,	tment o rtant; If ijury or		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Midshore	Cremation C	enter 12-			ridge	Maryland
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	ysician/ Medical kaminer		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the cause on each line. Due to (or as a lon Hangin	sequence of):	er the mode of dyin	g, such as cardiac		est,	/	Approximate Interval Between Onset and Death
70	sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	sequence of):						
30 e be executed	ysician and ne burial-trar	- I	that initiated events resulting in death) Last	Due to (or as a con	sequence of):						
Box 68760 e death certificate be	been signed by the attending physician and should be detached for use as the burial-transit	by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, outcome of pre 1 Live Birth 2 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnand Other (specify)	су			23d. Date of delivery Month Day Year	
Is, P.O.	n signed by uld be deta	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the								e cause of death?	
of Vital Records, g Physician: The law requires	certificate has bee irector, page 2 sho	Completed						24a. Was a autop perfor	rmed?	Were autor prior to cor death? 1 Yes	osy findings available mpletion of cause of 2 No
f Vital Physician:	this certificaral director,	Be	25. Was case referred to medical examiner?	spital:		_ Oth	ace of Death (Chec				
of V	this al d	e: To	27. Manner of Death	1 Inpatient	2 ER/Outpatie	130p_28c. Injur	4 ☐ Nursing He	ome 5 Resid			
Sion o	or: Afe the fun	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	fd (Month, Day, Yea Dec. 20, 20	01µ 4:5	4PM 1	Yes 2 X No	28d. Describe he subject neck wit			
Division Ital or Attendin	within 24 hours at er deat t. To the Funeral Director. Effer completely filled in by the funer		Ā	28e. Place of Injury - / building, etc. (Sp	ecify) Horr	e		Apt A	'ambrio) Cru	sader Road, D
Div	in 24 hou ne Funer pletely fil	Medical	(Check 2 Medical Examine	ian: To the best of my k r: On the basis of examir Practitioner: To the bes	nation and/or inves	stigation, in my opini	on, death occurred a	at the time, date a	nd place, and du	e to the cau	use(s) and manner stated.
Tot	To th	_	29b. Signature and title of certifier	MN mes	leal	29c. Licens	e number		29d. Date signer PECEVN	d (Month, l	Day, Year) 2(, 201(
			30. Name and address of person who cor	npleted cause of death	(Item 23a) (Type,	Print)	l Am	1 (Or. t.	ml	216	2(, 201(62
	Sta Registr		31. Date filed (Month P.C. Year)	32. egistrar's S	ignature)	and	· , /~ /	at 1	7		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ arie VION Dec Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Lare enter heste Orc. Social Security Number If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F Months Days Min. 06 Director Maryland items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No 10e. Street and Numbe 10g. Citizen of What Country? Funeral USA Chardson 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Black Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene.

Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Someone elses 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If Item 27 is 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location Date 1 Burial 2 Cremation 3 Removal from State Mithville Cometery 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Henry Funeral MD. 2/6/3 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as eardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Immediate Cause (Final disease or condition Demente Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or). sician and burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 2 NO 1 Tes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) funeral director. Hospital: Other: 2 No ျှ 1 🗌 Yes ER/Outpatient 3 DOA 1 Inpatient 2 4

✓ Nursing Home 5

☐ Residence 6

☐ Other (Specify) 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending after death. 2 No ☐ Accident Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined To the Hospital or within 24 hours a To the Funeral D Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nuyse Pragtioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 12-19. 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAMBRIDGE 3412 51

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

68760

Box (

Division of Vital

503

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42875 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER 13 Marita 2011 10:50 PM Cosby Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death HOSPITALOF BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months 078-26-7625 Director 1 □ M 2 😿 F 3/25/1931 80 NY show 10c. City, Town or Location Hampstead Baltimore 10d. Inside City Limits event, the Medical Examiner must be notified at Director or 28a-f 1 Yes 2 No 10g. Citizen of What Country?
USA 10f. Zip Code Funeral 18521 Brick Store Road 21074 23a 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian Armed Forces? 1 ☐ Yes 2 🕶 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. by 1 Never Married 2 Married ò altimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white If Yes, Give "natural" Completed 3X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles Garsia Edna Faust Department of Health and Meni Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice E. Kolman, daughter 18521 Brick Store Rd., Hampstead, MD 21074 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Carroll Cremation 12/15/201 Hampstead, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility M00741 Eline Funeral Home 934 Main Street, Hampstead, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA Phonician/ disease or condition resulting in death) Medical Due to (or as a consequence of): i BrillAtion Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of and resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 9 Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an has prior to completion of cause of death? autopsy certificate ! 2 No 1 Yes Be 25. Was case referred to edica 26. Place of Death (Check only one) examiner? 2 1 No Hospital Other: 1 🗌 Yes ၉ 1 Inpatient this 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death n 24 hours after death.

ne Funeral Director: After the pletely filled in by the funera 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) title of certifie 29b. Signature an 29c. License number 0006902 DECEMBER 13, 2011 WJZ 2401 W. Belvedere Be-Himore, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 SINAT MD HUSPITA JUSTIN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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MAR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 12 12 2011 Judith Ann Coufal 2:27 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Emeritus of Westminster Westminster Carroll Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, Year) 505-52-9321 **Director** 1 □ M 2 🔀 F 72 12/10/1939 NE show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits notified at Director 28a-f NC NW Calabash 1 ☐ Yes 2X No Brunswick 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 580 Montaigne Ct. 28467-2143 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Medical Examiner Armed Forces? Black, White, etc ö δ 1 Never Married 2 Married altimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: "natural" 3 Widowed 4 Divorced White Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Information Specialist G.E. Info Services of Health and Mental Hygier item 27 is marked other rother traumatic event, the Be Department of Health and Mental Hy Important, If item 27 is marked oth any injury or other traumation. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Max Wanser Ceceila Carr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert F. Coufal/husband 580 Montaigne Ct., NW Calabash, NC 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State ☐ Burial 2X Cremation 3 ☐ Removal from State 12/15/2011 | Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA Signature of Funeral Service Lice _ Y= 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that car shock, or heart failure. List only one cause on each nset and Dear Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as t attending ; IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No ate has been signed by the atte page 2 should be detached for Month Pregnant at time of death 1 Yes 2 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Director: After this certificate has autopsv Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accide
3 Suicide 5 Pending injury work? 1 □ Yes 2 □ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined after City or Town, State within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated WJL 15

State Registrar Rd Wastmy for MD2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month MARIECUTSHAN 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Takoma Park Washington Adventist Hospital <u>Montgomery</u> 5. Social Security Number 8, Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under **Funeral** June 19, 1956 Min. 577-78-2819 Director 1 🗆 M 2 🗶 F 55 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygene.
The entry is marked other than "natural", or items 23a or 28a-f show filen 27 is marked other than "natural", and items trannatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No MD Prince Georges Brentwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3606 41st Ave. 20722 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 XMarried 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify: White Specify: 3 - Widowed 4 - Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Park & Recreation Acti<u>vities Director</u> Be . Father's Name (First, Middle, Last)
Rujay Clark 18. Mother's Name (First, Middle, Maiden Surname) 2 Helen Marie Thornton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau James Cutshaw/ Husband 3606 41st Ave Brentwood, MD 20722 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Atlantic Crematory 1 Burial 2 XCremation 3 Removal from State 12/13/2011 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exam and I-tran that initiated events Due to (or as a consequence of) physician are the burial-t resulting in death) Last Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Vear Day Pregnant at time of death 2 No 9 Unknown 9 | Unknown n signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 3 Probably 4 Unknown Records, director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy Ke ailure 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify Hospital 2 No 1 🗌 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work?

1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: Director: After 1 Natural (Month, Day, Year) 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 24 hours after of Funeral Direct determined Medical 29a. Certifier Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29b. Signature and titl 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar Bryan M. Steinberg MD
31. Date filed (Month, Day, Year)
32. Bygistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Régistrar's Signature

10215

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 1 Physician/ Clements Iracu Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) HSE1 **Funeral** Hours **Director** 1 X M 2 □ F 200-56-6166 08/02/1964 47 Usual Residence of Decedent show 10b. County 10c. City, Town or Location aith and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho r traumatic event, the Medical Examiner must be notified at Director MD Montgomery Germantown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? by Funeral USA 20874 18511 Owl Run Way 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir 1 Never Married 2X Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced Completed Year or Dates 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Transportation Truck Driver 10th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Rose Mary Daniels George W. Clements, Sr. 19a. Informant's Name/Relationship (Type, Print) Sheila E. Clements/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Ardent Cremation Sv 12/22/2011 Signature of Funeral Service License eorg-23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final HNOXIC Physician/ brain disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine use as the burial transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown detached signed by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. page 2 should peen 24a. Was an 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 ☑ No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: injury 1 Natural 5 Pending Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical only one

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18511 Owl Run Way, Germantown, MD 20874 20c. Location - City or Town, State Hanover, MD 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 nterval Between Dinset and Death 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 12/20/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hysicians Ln + 152 Mittal 14816 MD ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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1354 PM

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 XYes 2 No

201

PA

14. Race - American Indian Black, White, etc.

Black

Specify:

Registrar

State

R.

DEC 21 201

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		State of Ma	iryianu /		tificate of				Glene Reg. No.	201	1 42879
	Physicia	an	1. Decedent's Name	,							2. Date of De Month	Day	Year	3. Time of Death
	/Medic Examin	al	Maria Ge		ive street and number)			4b. City, Town, o	or Location	on of Death	Decemb		7 2011 County of Dear	7:30 A W
	Examin	er	Carriage Hill of Bethesda Bethesda Montg								ontgome	ry		
	Funeral Director		5. Social Security Nu 579-62-65	umber 6.		92	oirthday) Yrs.	If Under 1 Year Months Days		der 24 Hrs. rs Min.	8. Date of Bir (Month, Did 01/13/	ay, Year)	9. Bir Co	thplace (State or Foreign ountry) Cuba
	land bw f		Usual Residence of 10a. State	Decedent 10b. County		10c. City, To	wn or Loc	cation						10d. Inside City Limits
	Mary a-f sh	ctor	MD	Montgo	nery	Che	evy (Chase						1 XYes 2 ☐ No
	h with the 23a or 28 st be not	Funeral Director	10e. Street and Num 4701 Will		nue		10f. Zip Code 20815					10g. Citizen of What Country? United States		
U3b	be filed within 72 hours after death with the Maryland that Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Everither must be notified at	ρ	11. Marital Status 1 ☐ Never Marrie 3 ☑ Widowed		12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		r in U.S. 13. Was Decedent of Hispanic Origin? (Specify Specify Cuban, Mexican, Puerto R						14. Race - Ame Black, Whit Specify:	
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yland	es 1 and 2 should be file of Health and Mental Hy i item 27 is marked oth r other traumatic event	To Be	17. Father's Name (1) Juan Gel		st)						e (First, Middle na Soli		Surname)	
Mary	2 shour and h		19a. Informant's Na					g Address (Stree				-		Zip Code)
	1 and Health em 27 ther t		Jose Rion 20a. Method of Disp		<u> </u>			olts Ln. sition (Name of natory or other pla	_		on, NJ		cation - City or	Town, State
E E	Pages nent of ant: If its ary or o		1 Burial 2 □		Removal from State			natory or other pla eaven Ce		12/20	1/11	S 1 1 3	zer-Spr	ing, MD
Baltimore,	permit. Pages 1 an Department of Hea Important: If item 2 any Injury or other once.		21. Signature			Joace	22	Name and Addr	ess of Fa	^{icility} Jose	eph Gaw	ler's	s Sons	Inc.
			23a. Part 1. Enter th	ne disease, or co	mplications that caused	the death. De							gcon, D	Approximate Interval Between
	Physician /		snock, or near Immediate Cause (I disease or condition resulting in death)	Final	y one cause on each lir Arteric a. Due to (or as	osclero		Cerebro	ascı	ılar D	isease			Onset and Death Years
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	P + 7	iner	Sequentially list con cause. Enter Under Cause (Disease or i	Topo Minto	Due to or as	a consequenc	e of:							
	and	Examiner	that initiated events resulting in death) L	ast	c Due to (or as	a consequenc	e of):							
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	certifica nding ph		IF FEMALE:		02a If you gutoomo	of programmy								
.C. Box	death e atter id for u	Physician/M	23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	23b. Was decedent pregnant in the past 12 months? 1									23d. Date of delivery Month Day Year	
ν. σ.	requires that the neen signed by the	by Ph			contributing to death bu	-			iven in Pa	art I.	23e. Did	tobacco u	se contribute t	to the cause of death?
ecords	equire een siç ould b	ted k	Pneumonia Dementia	a, Failu	re to Thri	ve, Car	ncer	Colon,			1 🗆	Yes 24	No 3□ F	Probably 4 Unknown
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	iding Physician: th. After this certifica funeral director, p	Be C	25. Was case referr examiner?	red to medical	11						h (Check only	one)		
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0	nding ith. :: After e fune	ation	1 X Natural 2 Accident	5 ☐ Pending investigat	(Month, Da)	y, Year)	Injury	We	ork? ∐Yes 2		Edd. Deddillo	now man	, 55541154	
DIVISION	al or Attending F after death. I Director: After d in by the funera	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not determine		ury - At home, c. <i>(Specify)</i>	farm, str	eet, factory, office			28f. Location City or To	(Street an wn, State	d Number or F)	Rural Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Certifier (Check only one)	1 X Certifying 2 Medical Ex	Physician: To the best amlner: On the basis o and manner sta	f examination	dge, deatl and/or in	h occurred at the vestigation, in my	time, dat opinion,	e and place, death occur	and due to th	e cause(s	and manner a place, and du	as stated. ue to the cause(s)
	To the within To the Comp	Me	29b. Signature and		C 2			29c. Licer					te signed (Mon	
	12				sundar,				3367			12-1	19-2011	
					o completed cause of d				17 0	TT 17000	CDDING	3.47	20002	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 24a per med cert G923
I/111/12/06
State of Maryland / Department of Health and Mental Hygiene 2011 42880 For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ M 1400 James Anthony Calemine Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Cumberland WM Regional Medical Center If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Hours 218-60-0245 1 ★ M 2 □ F **Director** 58 5/15/1953 TN 28a-f shov 10d. Inside City Limits 10c. City, Town or Location an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 X Yes 2 No WV Mineral Keyser 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Funeral 26726 287 Welch Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 X No þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates Specify: White 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiers Important. If item 27 is marked other than any injury or other traumatic event, the Meannee. Elementary/Secondary (0-12) Medicine Pharmacist Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) ပ Dominick V. Calemine Colleen London 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 287 Welch Street, Keyser, WV 26726 Pamela Calemine/wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/31/11 Keyser, W Thomas Cemetery 21. Signature of Funeral Service Lice 22. Name and Address of Facility tarold Dean Markwood Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. WV piratory Interval Between Onset and Death Physician/ C disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ▼ No 26. Place of Death (Check only one) director, 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred funeral 27. Manner of Death Certificate: injury 1 Natural 5 Pending Accident
Suicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou

To the Funer

completely file Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29b. Signature and title of certification 0066434 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Blanche Mavromatis, M.D.-12502 Willowbrook Rd. Suite 300 Cumberland, MD 21502 32. Pagistrar's Signature State Registrar

Dy.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2011 0559 am Carroll Anthony Camper December 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CAMBRIDGE DOKEHESTER GENERAL HOSDITAL 8. Date of Birth (Month, Day, Year) Sept. 18,1953 5. Social Security Number 1 XM 2 □ F Maryland 218-58-1043 58 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 XYes 2 ☐ No Cambridge Maryland Dorchester 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number USA 21613 514 High Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: Specify: Black 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machinist Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Louise Stanley Robert Carroll Camper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 766 Cornish Drive, Cambridge, Maryland 21613 Tykisha Camper/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Crematory Of Delmarva 1/4/2012 |Delmar, Delaware 4 ☐ Donation S ☐ Other (Specify) 22 Name and Address of Facility 21. Signatur of Fureral Service Lige Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, 21631 Approximate Interval Between Onset and Death Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enock, or heart failure. List only one cause on each line. Immediate Cause (Final Cardian yopathy disease or condition resulting in death) Due to (or as a consequence of): Stage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a consequen a) Due to (ohas a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. a 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 26. Place of Death (Check only one) Hospital:

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

or items 23a or 28a-f show

Director

Funeral

ð

Completed

Be

Examine

Physician/Medical

Completed

Certification: To

Medical

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Moulcal Examination until the particular once.

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed and burial-tran attending physician the as use ō the þ signed I has

Box 68760.

P.0.

Records,

Division of Vital

page 2 certificate

e Hospital or Attending Physician; 24 hours after death. Funeral Director: After this certifica completely filled in by the within 2 the 0

Second
25. Was case referred to medica examiner?

JAN 05

27. Manner of Death

Natural 2 Accident

3 Suicide

29a. Certifier

4 🔲 Homicide

(Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who

31. Date filed (Month, Day, Year)

and manner stated

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND#2perMD, 12/18/13:12/04/Maryland / Department of Health and Mental Hygiene 1 - State AMEND#10a,b,cperFH,12/22/11;b/W,McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Dear 3. Tir Day 2011 Physician/ 2344 Davis Dec. 13, Crystal Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days Min (Month, Day, Year) Country) Director 577-19-3201 1 □ M 2**X** F 32 10,1979 WashingtonDC Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City. Town or Location with the Maryland Examiner must be notified at Director 1 🎇 Yes 2 □ No Washington, D. D.C. None 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? o Funeral 20011 USA items 23a 58 Tuckerman Street N.W. filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc 1 X Never Married 2 ☐ Married "natural", or by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+) I Hygiene. <u>Human Resurces Specialis</u>t Private Company 4 year Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Department: If item 27 is marked off any injury or other traumatic event 17. Father's Name (First, Middle, Last) Carrol Jeanette Cooper Clifton Earl Davis, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Tuckerman St. N.W. Wash. DC 20011 Clifton E. Davis, Jr/Fathet58 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State Brentwood, MD 12/28/11 Lincoln 4 ☐ Donation 5 ☐ Other (Specify) s Funeral Home 22. Name and Address of Facility Latney 21. Signature of Full ral Service Licensee 3831 Georgia Avenue, NW Wash.DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Shock Septic disease or condition resulting in death) Medical **Examiner** Hypovolemia Diminished Blood Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Dise to for as a nonsectionnel of Hospital or Attending Physician: The law requires that the death certificate be executed Sickle Cell Crisis attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Sepsis Division of Vital Records, P.O. Box 68760 as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2X No Month Day Year Pregnant at time of death 1 ☐ Yes ∠ the Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by 1 🗌 Yes 2 🗌 No 3 🗌 Probably 4 🛣 Unknown Acute renal failure Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Severe anemia has autopsy death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 1 Yes 2 X No 1 ▼ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 XNo 1 X Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) X Natural 5 Pending 1 Yes 2 No Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 - Homicide determined Medical Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 12/17/2011 DOO 6 4100 Nex (A MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Smitha Bhikkaj 1500 Forest Glen Rd. Silver Spring, MD 20910 Smitha Bhikkaj 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2 2 2011 DEC Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			. For	State of	of Maryla		artment of H		nd Ment	al Hygi	ene		
		_1	State Registrar			Cer	tificate of L	Death		Reg	g. No. 2	n L	1. 1.2223
	Physicia	,	1. Decedent's Name (First, Middle							ate of Death	Day	Year	3. Time of Death
	Medic	al .		WARD	DEATE	R				onth CEMBEF		2011	
	Examin	er	4a. Facility Name (if not institution, FREDERTCK M	_		Г.	4b. City, Town, or FREDER		Death		4c. County		
	Francis		5. Social Security Number	6. Sex		. last birthday)	If Under 1 Year	If Under 24	1 Hrs. 8. Da	ate of Birth	11111	a Rirth	nplace /State or Foreign
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9	or ite	ഉ	1 Never Married 2 ☐ Marr	ried Armed Fo	2 🔼 No		f Yes, specify Cuba 1 ☐ Yes 2 🌁 No		Puerto Rican,	, etc.)		ack, White	
3	n 72 hours after death with the Maryland an "natural", or items 23a or 28a-f show Medical Examiner must be notified at	Ted	3 Widowed 4 Divorced	If Yes, Gi Year or D			I □ Yes 2 □ No	Specify:			Specify	y: Whi	te
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12	ithin 7 ene. • than	Completed	Elementary/Seconday (0-12)	College (1-4 or 5+)		O NOT use retired) ectrician				elec	tric	a1
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<u>a</u>	be fil lental rked tic ev	욘	Charles H. Deat	er, Jr.				Anna	Lea De	elaute	r		
Maryland 21215-0036	a 1 and 2 should be filed within of Health and Mental Hygiene. If item 27 is marked other thar rother traumatic event, the M		19a. Informant's Name/Relationsh			19b. Mailir	ng Address (Street	and Number o	or Rural Rout	te Number, C	ity or Town,	State, Zip	Code)
	nd 2 sealth an 27 i		Mary Heffner/si	lster		672	5 Kernel	Ct., F	reder	ick, M	D 2170	03	
ore	ge 1 ar nt of He : If iter or oth		20a. Method of Disposition 1 Burial 2 □ Cremation	3 Removal from		. Place of Dispo cemetery, crer	sition (Name of natory or other plac	ce)	Date	2	0c. Location	- City or	Town, State
Ě	Page 1 Iment of tant; If it jury or o		4 Donation 5 Other (S	Specify)		luster_			2/21/2				
Baltimore,	permit. Page Department of Important; If any injury or once.		21. Signeture of Funeral Service L	icensee			2. Name and Addre						
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	Pillion in Continuo II		shock, or heart failure. List of Immediate Cause (Final	only one cause on e	each line.		,	J,		,			Interval Between Onset and Death
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89	certifi nding use a	N/N	IF FEMALE: 23b. Was decedent pregnant		utcome of preg		☐ Ectopic pregnan	01/			23d. D	ate of deli	very
Box	death e atte	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No		gnant at time o		Other (specify)				N	onth	Day Year
0	t the c by th stache	Phy	g Unknown		-	reculting in the	underlying course gi	von in Port I		00 - Did tob		atribusta ta	the cause of death?
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ဝ၁	has the	mpl							- [autopsy	,	prior to death?	completion of cause of
ř	n: The ficate or, pag		25. Was case referred to medical	1		_	26 P	lace of Death		perform 1 Ves 2	No	1 ∐ Yes	2 No
Ita	s certi	To Be	examiner? 1 Yes 2 No	Hospital:	Inpatient 2	☐ ER/Outpatie	Oth	or	sing Home		nce 6 🗆 Ot	her (Speci	f(v)
of	g Phy er this seral c		27. Manner of Death	28a. Date	e of injury onth, Day, Year)	28b. Time o		γ at		Describe hov			
Division of Vital Records,	endin eath. or: Aft he fur	fica	1 Natural 5 Pendir 2 Accident Investi 3 Suicide 6 Could	gation		,,		Yes 2 N	No				1.5.4.14.5
N	or Atter de lirecton by t	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	inod 28e. Plac	e of Injury - At ding, etc. (Spec		reet, factory, office			ocation (Stre City or Town,		ber or Rui	al Route Number,
$\overline{\Box}$	pital ours a eral C		29a. Certifier 1 Certifying	Physician: To the	hest of my kno	owledge death	occured at the time	a date and nl	lace and due	to the cause	e(s) and man	ner as sta	ted.
)	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical I	Examiner: On the banks Nurse Practioner	asis of examina	tion and/or investing knowledge,	stigation, in my opini death occurred at the	on, death occi	curred at the ti and place, and	me, date and d due to the o	place, and d ause(s) and r	lue to the o	cause(s) and manner stated. stated.
/	To the within To the To the To the To the Comp	~	29b. Signature and tille of certifie				29c. Licens	e number	_	29	d. Date sign	ed (Month	, Day, Year)
	,		1				200	6222	3		12/	16/1	(
	7		30 Name and address of person	who completed car		em 23a) (Type,	occurred at the time stiggation, in my opinideath occurred at the stiggation of the	A CAR	11111	MI	2	170	2.
8	Sta	· 0	31. Date filed (Month, Day, Year)	32.	Registrar's Sig	nature	INCOU, (UCHUI	iu ur				
	Sta	e ar	DFC 2		Decrease 1	1 1	backer						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Angelia Douglas December 23, 20/1
4c. County of Death /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Wicomico Salisbury Rehabilitation Wursing Ctr. 5. Social Security Number 6. Sex 7. Age (In yrs. last bildhday) 5 Du If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 02/09/1957 Virginia 1 □ M 2 🛛 F 54 216-70-6565 Director Usual Residence of Decedent 10d. Inside City Limits 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County ms 23a or 28a-f show must be notified at 1 Yes 2 □ No Salisbury Directo Maryland Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21804 802 College Lane, Apt. A items 23a Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. ☐Yes 2**X** No Yes, Give 1 ☐ Never Married 2 ☐ Married "natural", or 1 ☐ Yes 2X No Black Baltimore, Maryland 21215-0036 þ 3 Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Law Firm Secretary 12 permit. Pages 1 and 2 should be ⊪ed i Department of Health and Mental Hygic Important: If item 27 is marked other i any injury or other traumatic event, <u>tt</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Leah Catherine Jones Lillton Powell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 433 Bailey Lane, Salisbury, MD 21801 Lilton Powell/brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Salisbury, MD Salisbury Crematory 12/27/2011 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Stewart Funeral Home by Holloway and Downey, P.A 821 West Rd., Salisbury, MD 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) liabe Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury Due to res a consequence of): Examiner The law requires that the death certificate be executed sician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) 1 □Yes 2 □ No the detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 s autopsy perform 2 No certificate filled in by the funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 27 No 1 Inpatient 2 TER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Yes this 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of After (Month, Day Year) Injury To the Hospital or Attending 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide Seculifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely

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Angel

State

Year) 2 7 Registrar

title of certifier

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200 Livic Begistrar's Signature

of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 42885 Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ RUR 40MAS 7:00PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arunde 1 **Examiner** Harwood Mandrin Hospice House 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours (Month, Day, Year) Director 215-78-5754 1 X M 2 🗆 F 12/09/1959 Maryland 52 Usual Residence of Deceden items 23a or 28a-f show her must be notified at with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Anne Arundel Millersville 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Funeral 21108 USA 1086 Dicus Mill Road within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, er than "natural", or iter the Medical Examiner Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 Yes X If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: White Completed 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry oe filed with. ral Hygiene. 'ser than "r Elementary/Secondary (0-12) College (1-4 or 5+) Cowboy Agriculture permit. Page 1 and 2 should be filed witl Department of Health and Mental Hygier Important: If item 27 is marked other 1 any injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည VanMeter Elizabeth Ann William Vincent Drury Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3428 Shiloh Road Hamstead, MD 21074 Thomas Drury IV 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glen Haven Cemetery 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 12/19/2011 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Hardesty Funeral Home P.A. Gambrills, MD 21054 22. Name and Address of Facility Tal 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ -UNG monnts disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner SMOKING Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has I autopsy performe 24 hours after death.

Funeral Director; After this certificate letely filled in by the funeral director, pag 1 Yes 2 No Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Vatural 5 Pending Accident 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🙀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 52756

State Registrar istrar's Signature

Defense Huy Armapolis MD 21401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** 1:05 Paul Christopher Day 24 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Atlantic General Hospital Berlin Worcester If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ kM 2 □ F 215-54-6787 54 8/7/1957 MD Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show ltem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1XYes 2 No Director Worcester Ocean City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 181 Jamestown Rd. 21842 USA Funeral Hygiene. other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 No If Yes, Give 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ white 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 Sous Chef Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Donald E. Day Shirley Stahl 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 shr Department of Health and Important: If Item 27 is m any injury or other traum. once. 19a. Informant's Name/Relationship (Type. Print) Shirley Day / mother 1846 Meridian Dr., Hagerstown, MD 21742 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State First State Crem. 12/26/11 4 ☐ Donation 5 ☐ Other (Specify) Millsboro, DE 21. Signature of Funeral Service Licens 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myocordia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any second cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of and Due to (or as a consequence of) physician al s the burial-t 68760, Physician/Medical attending ph IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 ☐ Other (specify) □Yes 2□No o 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate has 1 ☐ Yes 2 No Vital 1 □Yes_ 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this Division of 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After (Month, Day, Year) 1X Natural Injury 5 Pending 1 ☐Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier cal 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10064120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ATIF ZEESHAN. Berlin MD 21811 DAN 6 m've 9733 Health Way 31, Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 18 Bay Physician/ Month 2011 9:15 A M AGAPITO LOUIS DILONARDO Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY DICKERSON 20311 DICKERSON CHURCH ROAD Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days (Month, Day, Year) 5 / 2 3 / 1 9 1 7 Months Hours Min. 94 Director 161-01-1240 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director MONTGOMERY DICKERSON 1 Yes 2 No MD 10f. Zip Code 10e. Street and Number ö 10g. Citizen of What Country? Funeral items 23a USA 20842 20311 DICKERSON CHURCH ROAD hours after death 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. ō 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: WHITE "natural", 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than U.S. GEOLOGICAL Elementary/Seconday (0-12) College (1-4 or 5+) CARTOGRAPHER SURVEY Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ ROSE BIRARD permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic LOUIS A. DILONARDO 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
R 213 MONROE ST., PHILADELPHIA, PA 19147 19a. Informant's Name/Relationship (Type, Print) KATHLEEN DILONARDO/DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State STAUFFER CREMATORY 12/20/2011 FREDERICK, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licer 22. Name and Address of Facility P.O. BOX 86 HILTON FUNERAL HOME BARNESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a MYELOPROLIFERATIVE DISORDER disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner MYELODYSPLASTIC SYNDROME Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): iding physician Physician/Medical death certificate be Box 68760 the as nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Pregnant at time of death Day 4 ☐ Pregnant g ☐ Unknown 9 Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>호</u> Hospital or Attending Physician: The law requires Records, 3 Probably 4 Unknown 1 Yes 2 No been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy Yes certifica **Division of Vital** 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Hospital 2 🗹 No Other: 욘 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 \(\square\) Nursing Home 5 Residence 6 Other (Specify) this 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After injury work? Natural 5 Pending 124 hours after death.

Per Funeral Director: Al pleted filled in by the fu ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check To the I within 2 only one 29b. Signatu 29d. Date signed (Month, Day, Year) 29c. License number DECEMBER 19, 2011 D35635 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 JOSEPH KAPLAN, MD9715 MEDICAL CENTER DR., #221, ROCKVILLE, 31. Date filed (Month, Day, Year) Registrar's Signature State reun Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42888 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 17 Leigh Burdette 20T1 8:28 a.M Edger Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Dorchester Chesapeake Woods Center Cambridge . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Oct. 18, Year 1933 Marvland 219-36-6950 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Dorchester Cambridge 1 Yes 2 X No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 5608 Cassons Neck Road 21613 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? þ 1 Never Married 2 Married white 1 ☐ Yes 2 ¥ No Specify: If Yes, Give 1953-56 Year or Dates. Specify: Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) hospital cook Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James W. Edger Sara DeMott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) April D. Edger 5608 Cassons Neck Road, Cambridge, MD daughter 20a, Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cremetery, crematory or other place)
Crematory of Delmarva 12/19/11 1 Burial 2 K Cremation 3 Removal from State Delmar, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licer 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Condoverender discere Arteriosciardhe Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or self-rionesquance of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 Ano 24a. Was an performed' completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 14 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar

(Check

29b. Signature and title of certifier

NOMAN

31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signatur

Baltimore, Maryland 21215-0036

Box 68760

P.O. I

Division of Vital Records,

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

7924

CAMBRIDGE MD 21613

29d. Date signed (Month, Day, Year)

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For Amend I tems 23dPtI, 25 per me, 0923, 01/26 thand Mental Hygiene 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 25, 2011 6;40 Harvey Robert Foskey Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WORCESTER ATLANTIC GENERAL HOSPITAL BERLIN 5. Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1**₹** M 2 □ F Months Days Hours Min 1270971958 Maryland 216-70-1911 53 Director Usual Residence of Decedent show or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Wicomico Pittsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō and Mental Hygiene. is marked other than "natural", or items 23a or aumatic event, the Medical Examiner must be Funeral 21850 7676 Maple St. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 🕱 No Black. White, etc. δ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Carrier Newspaper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any inJury or other traumatic ev Elsie Margaret Davis Vincent Crisfield Foskey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7676 Maple St., Pittsville, MD 21850 Sylvia Emerick/sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/27/2011 Salisbury Crematory Salisbury, MD ign, ture of Funeral Service Licenses ²²Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ w diac disease or condition resulting in death) Medical Due to (or as a consequence of) §Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions, Examine Due to for as a punsequence offer if any, leading to immedicause. Enter Underlying Probable Myocardial Infarction Cause (Disease or linjury tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 morths?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy 4 Pregnant 9 Unknown 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hospital or Attending Physician; The law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 25. Was case referred medical examiner?

1 X Yes 2 1 No Be 26. Place of Death (Check only one) Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deat Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Centifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only o 29d. Date signed (Month, Day, Year) D00070381 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Stephen P. St. Pierre, M.D.

DEC 27

31. Date filed (Month, Day, Year)

32. Registrar's Signature

9733 Healthway Dr., Berlin, MD 21811

11-09582 Carrie Fletcher Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2011 42890

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Physicia		Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death		3. Time of Death					
Medical Exami		Carrie Arrington Fletcher	Month Da December 21	y Year I, 2011	1450 hrs					
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deat	h	4c. County of Death						
		Peninsula Regional Medical Center Salisbury		Wicomico						
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr Months Days Hours Mi	`	MM/DD/YYYY) 9. Birt Foreig	1					
Director		231-26-1723								
	- [Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits					
ж апу					1 Yes 2 X No					
Maryland 28a-f show 1 at once.	ġ	Maryland Wicomico Eden 10e. Street and Number 10f. Zip Code	100.0	Citizen of What Cour						
or 28a	Director		109.							
hours after death with the Maryland natural", or items 23a or 28s-f sho Examiner must be notified at once.	믧	28105 Allen Cut-off Road 21822 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (\$\frac{1}{2}\$)	Specify Yes or No-	USA 14. Race - Americ	an Indian, Black					
ath Wi	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puert		White, etc.						
		1 Yes 2 No 3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify:		Specify: Blac	k					
urs af	ğ	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of		b. Kind of Business/I						
72 ho	ete	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use re FOST er								
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21215-0036 and be filed within 7 Mental Hygiene. marked other that it event, the Medica		Tr. I date o Hamo (i ilai, madio, Eday)	ne (First, Middle, Maid	len Surname)						
d be f fental	Be	Alex Arrington Mattie V 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or	Villiams	City or Town State	Zin Code)					
MD 2 id 2 shoul lith and M m 27 is m sumstic	မှ	Jeremiah Arrington/son 1101 Brittingham Stre								
	1	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date 20	Oc. Location - City or	Town, State					
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 X Burial 2 Cremation 3 Removal from State crematory or other place)	/00/0011	** 1	3 3					
it. Pa	1	4 Donation 5 Other Specify: Springhill Mem. Gdns 12 70. Si nature of Funeral Service Licensee 22. Name and Address of Facility 123	/29/2011 3 Tersev	<u>Hebron, M</u> Road Salis	aryland bury MD					
Ba Perm Depa injur		Patrices a Jalley Jollev Memorial Ch		218						
Physician	┪	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	or respiratory arrest,	shock, or heart	Approximate Interval Between Onset and					
Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease			Death					
ZXAIIIIIICI		or condition resulting in death) Due to (or as a consequence of):								
	<u>_</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):								
	Ě	cause. Enter Underlying Cause (Disease or injury that initiated								
ed asit	Examiner	events resulting in death) Last Due to (or as a consequence of):								
OX 68760, ath certificate be executed attending physician and or use as the burial - transit	Medical	d. UNPENDED AMENUES								
60, ate be e	ğ	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery	<u> </u>					
1876 tifical ng ph	릙	23b. Was decedent pregnant in the past 12 months?			ay Year					
Box 687: death certification and for use as the	Si	4 Pregnant at time of death 5 Other (Specify)								
be dez	Physician/	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e Did tobac	cco use contribute to	the cause of death?					
Division of Vital Records, P.O. B tal or Attending Physician: The law requires that the d its after death. al Director: After this certificate has been signed by the led in by the fumeral director, page 2 should be decembed	<u>a</u>	Takin, other significant containers.	1 Yes 2	2 No 3 Prob	ably 4 🗸 Unknown					
ords, P w requires the second of the second	Completed		24a. Was an		topsy findings available					
COLO	쀨		autopsy performe	d? death?	ompletion of cause of					
tal Rection: The certificate ector, page	ठ	Of Division of Division (Division)		No 1 ✓ Ye	s 2 No					
Vital Rec ysician: The l his certificate l	å	25. Was case referred to medical examiner? Hospital: ↑ Inpatient 2 ✔ ER/Outpatient 3 DOA Other ↑ Nurs	sing Home 5 Res	sidence 6 Other						
Physical directions	P	1 Yes 2 No Pate of Injury (Month, Day, Year) 27. Manner of Death 28. Date of Injury (Month, Day, Year)	28d. Describe how		·					
n of Anding Ph	Ë	1 Natural 5 Pending (Month, Day, Year) 1 Yes 2 No								
isior Attender death	Sat	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.			ral Route Number, City					
Divisipital or At ours after dours after diffiled in by	Certification:	3 Suicide 6 Could not be determined (Specify)	or Town, State	9)						
Hospi 24 hot Funce tely fil		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an	nd due to the cause(s) and manner as stat	ed.					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial—transition.	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.								
FSFS	ž	29b. Signature and title of certifier 29c. License number		9d. Date signed (Mo.						
		Callell L O.C.M.E.		December 22, 20) 1 					
UE		30. Name and address of person who completed cause of death (Item 23a)	MD 21223							
		Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore 31. Date filed (Mg/rth, Day Year) 114 32 Registrar's Signature	5, IVID 2 1223							
St Regist	ate	TIPL Z / /UII // A Z / /								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2.25 PM HORATIO Medical 4a. Facility Name (if not institution, give stre 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Westminster Carrol1 If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F April 15, 60 Months Hours Min. Director 216-46-8046 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland be notified at Director MD Sykesville Carrol1 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23 USA 21784 7309 Second Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. Completed by 1 X Never Married 2 ☐ Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 ☐ No Specify: If Yes, Give White 3 Divorced 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Draftsman Engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Horatio Stanley Fox Carly Krupinski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 179 E. Main St., Westminster, MD 21157 Charles O. Fisher (personal rep 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pleasant Cemetery 12/14/2011 Gamber, MD Signature of Funeral Service Licenses 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ≁nysician/ 6 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or a consequence of The law requires that the death certificate be executed for use as the burial-transit Theumoni and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? the g Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate 1 Yes 2 No Yes 2 1 within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Impatient 2 I ER/Outpatient 3 I DOA 27. Manner & Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and itle 2006332 WJL MD 30. Name and addre s of person who completed cause of death (Item 23a) (Type, Print) 200 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 12/716/2011 Kathleen S. Fiddler 8 P Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 578-74-6103 1 🗆 M 2 🔀 F Director 58 01/28/1953 Indiana Usual Residence of Decedent shov 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director MD 28a-f Anne Arundel Annapolis 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō rms 23a or Funeral 1930 Pendennis Drive 21409 USA er than "natural", or items the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 X Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b, Kind of Business/Industry Homemaker use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home 03 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George F. Esenwein Suzanne Berkey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1930 Pendennis Drive Annapolis MD 21409 Robert Fiddler Spouse 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Atlantic Crematory 12/19/2011 Glen Burnie,MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 22. Name and Address of Facility
Hardesty Funeral Home P.A. Annapolis, MD 21401 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as carding or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to as a consequence of **Examiner** Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Physician/Medical Examine Due to for as a consequence of: the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 4 ☐ Pregnant a
9 ☐ Unknown been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Ves 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 within 24 hours after death.

To the Funeral Director: After this certificate has director, page 2 death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 🗌 Yes 1 npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) Medical Certificate: Manner eath 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Matural iniury 5 Pending Accident Investigation completely filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State

31. Date filed (Month, Day,

DEC 2 0 2011

(Check only one) 29b. Signature

30. Name and address of

ompleted cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License numbe

29d. Date signed (Month, Day, Year)

120

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 15, 2011 Physician 9:00 AM M December MELVIN MILLER FEDERLINE, SR. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick 11020 B Powell Road Lewistown 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1**X** M 2□ F Days Hours Min. Maryland Director 29, 1922 216-14-6988 89 Oct. Usual Residence of Decedent 10d. Inside City Limits the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 1 Yes 2 □ No Directo Lewistown MD Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21788 11020 B Powell Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 1943-Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 🗓 No If Yes, Give Year or Dates: 1945 Specify: Specify: Be Completed by White 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Engineering Ordinance Aide 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Emma Elizabeth Rothenhoefer Walter Miller Federline ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11026 Hessong Bridge Road, Thurmont, Maryland 21788 <u>Sharon L. Eaton/ Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 12/19/2011 Frederick, Maryland <u>Resthaven Memorial</u> 21. Signature of Funeral Service License Robert Edward Son Funeral Homes, P.A. 615 East Main Street, Thurmont, Maryland 211 23a. Part 1. Enter the disease, or corn, lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 06 **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 1 Live birth 2 Fetal death 3 - Ectopic pregnancy Month 5 ☐ Other (specify) Division of Vital Records, P.O. 9 \ Unknown 9 Unknown Part II. Other significant conditions contributing 🔌 death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 **1**00 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 ANO 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Mann of Death 28d. Describe how injury occurred 5 Pending investigation 1 Uf atural 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🖵 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 100 South Center Street, Thurmont, Maryland William F. Harper, MD, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

7:00 am

Virginia

u.s.A.

Caucasian

10d. Inside City Limits

1 Yes 2 X No

MD 20852

Approximate Interval Between Onset and Death

12-20-11

Registrar DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D..

John Marshall.

31. Date filed (Month, Day, Year)

DC 19653

3800 Reservoir Road, NW, Washington, DC 20007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra AVEND#200+coerFH; 12/28/11; BW, Mcco Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 16 =lla Year 201 Physician/ 10:55AM Fisher Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Future Care Pine View Nursing Home Clinton Prince George's If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 07/16/1920 1 M 2 F Months Days Hours Min. Country) 91 Director 577-58-0518 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f shor aumatic event, the Medical Examiner must he notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8804 Creek Way Drive 20735 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give 3X Widowed 4 Divorced Black Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 7th Food Service Worker US Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James O. Gassaway Blanche Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shot Department of Health an Important: If item 27 is Beverly Singleton/daughter 8804 Creek Way Drive, Clinton, MD 20735 20a. Method of Disposition 20b. Place of Disposition (Name of Gatement Comment) 20c. Location - City or Town, State Silver Spring, I Clinton, MD 1 🕅 Burial 2 🗌 Cremation 3 🗌 Removal from State 12/29/2011 injuny Resurrection Cem. 4 Donation 5 Other (Specify) Snowden Funeral Home Signature of Funeral Service Licens 22. Name and Address of Facility 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Hrtery Disease Coronary disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician ched for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death detached 9 Unknown P.O. þ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? by þ forellation Records, 1 Yes 2 No 3 Probably 4 Toknown Completed ed filled in by the funeral director, page 2 should been 24b. Were autopsy findings available Staca 24a. Was an has prior to completion of cause of death? autopsy performed certificate 1 Yes 2 No 2 - N Hospital or Attending Physician: 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner? 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After t Natural work?
1 Yes 5 Pending Division 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certi-29c. License number 29d. Date signed (Month. Dav. Year) Jecember 16 2011 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 42896 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ GRAEFF 10:20 P.M December 20,2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 7. Age (In vrs. last birthday) 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 M 2 L 180-14-0715 Hours Min Dec. 10, 1921 **Director** 90 Czechoslovakia Usual Residence of Decedent or items 23a or 28a-f show miner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Rockville 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20852 U.S.A. 6111 Montrose Rd. #516 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No "natural", or item edical Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: White 3 ☐XWidowed 4 ☐ Divorced Specify: Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natul any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Salesperson Clothing Be 18. Mother's Name (First, Middle, Maiden Surname)
Frieda Schwartz 17. Father's Name (First, Middle, Last) Sandor Honiq 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20815 Stephen Graeff 3910 Rosemary St., Chevy Chase, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🕅 Burial 2 □ Cremation 3 🕅 Removal from State Crescent Memorial Pk. Dec.22,2011 Pennsauken, NJ 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or residence, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Intracranial Hemorrhage Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) RS signed by the attending physician and a be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical death certificate be yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Fa11 Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate the Completed filled in by the funeral director, page performed? death? 1 ☐ Yes 2 🗙 No 25. Was case referred to medical **Division of Vital** Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 🗆 No 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury Investigation

6 Could not be determined 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐**X**No ☐ Natura! 11:00 A M Accident Suicide fall 3C. ZU, ZUII F--28e. Place of Injury - At home, farm, street, factory, of the opping ---building, etc. (Specify) rson St. mail 28f. Location (Street and Number or Rural Route Number, 4 Homicide 1776 E. Jefferson St. Rockville Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29d. Date signed (Month, Day, Year) 1/006 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Rd., Bethesda, MD 2081/4 James Hika, MD 31. Date filed (Month, Day, Year) State DEC 2 2 2011 Registrar

10:30pm

Marion

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Amelie Henriette Gorgen Month 12 2011 9:45 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3411 Dulaney Place Burtonsville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Yea May 7, 1922 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign 1 □ M 2 🛣 F Hours Germany 133-30-4780 89 Director Usual Residence of Decedent 28a-f show 10a. State 10b County "natural", or items 23a or 28a-f sho dical Examiner must be notified at 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 X No FL Martin Stuart 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 144 N. E. Edgewater Dr., #3207 34996 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed Specify: 3 X Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important; If item 27 is marked other than "any injury or other traumatic event, the Mea one, Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Emil Mingels Gertrude Hahn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Suzanne G. Foley/Daughter <u>3411 Dulanev Place, Burtonsville, MD 20866</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State Atlantic Crematory, LLC 12/22/2011 Glen Burnie, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Cole Funeral Services, P.A. 22. Name and Address of Facility 4110 Aspen Hill Rd., #100, Rockville, MD 20853 23a. Part 1. Enter the disease or co shock, or heart failure. List only mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Opset and Death

Vrs Immediate Cause (Final Physician Aortic Stnosis disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Myelodysplastic Syndrom 3 mos Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Anemia Due to (or as a consequence of): burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as attending IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No ō Month Day Year signed by the at d be detached fo Pregnant at time of death Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Xunknown Completed page 2 should . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? After this certificate 1 Yes 2 No Yes 2 X No within 24 hours after death.

To the Funeral Director: After this certific spendieted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) x Daughter's home Hospital Other: 4 Nursing Home 1 ☐ Yes 2 🛚 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D35996 Dec. 21, 2011 University BIvd. #400, Wheaton, MD 20902 31. Date filed (Month, Day, Year, State 2 2 2011

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	py		ried 2 Married	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.)	1	f Yes, spe	cify Cuba	n, Mexicar Specify:	n, Puerto	Rican, etc.)			k, White,		
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Luneral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the br	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2 9	months?	23c. If yes, outcome 1 Live Birth 4 Pregnant 9 Unknown	2 Feta	ıldeath 3 ⊑	Ectopic Other (s)		у				23d. D <i>a</i> Mo	te of deliv	/ery Day	Year
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To t With To t		29b. Signature and	title of certifier Sky wal	niMin.			290	License	number 574	165			ate signed		Day, Year)	
44		N.S. Rujapi	arse in ic	completed cause of c	death (Item	23 <i>a</i>) (Type, P	Print)	5-	203	Ĩ	Baltin	rone	MC) 7	217 (79
Stat Registra		31. Date filed (Month	DEC 20	2011 32. Registr	ar's Signat	ure f.	back	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. D#19b per FH State of Maryland / Department of Health and Mental Hygiene 20/2011 AACO HEALTH DEPT. OH Cortificate of Death For AMEN State 12 42899 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death GRAEFF Year Physician/ OR Month GE 1947 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel <u>Annapolitan Assisted Living</u> Annapolis 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Hours 214-12-9255 91 **Director** 1 2M 2 □ F 7/3/1920 Maryland Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Maryland Anne Arundel Sherwood Forest 1 Yes 2 X No 10e Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 21405 USA items 23a Funeral 662 Maid Marian Hill death v 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Examiner Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates. 1 Yes 2 X No Specify: WWII Specify: "natural", 3 X Widowed 4 Divorced White Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than College (1-4 or 5+) Elementary/Secondary (0-12) the PGA Golf Professional Sports Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: if Item 27 is marked to any injury or other traumation once. 2 George Graefe Margaret Keilholtz 9b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) George E. Graefe III - Son -Maid Marian Hill, Sherwood Forest, MD 21405 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 DeBurial 2 Cremation 3 Removal from State Cedar Bluff Cemetery: 12/20/2011 4 ☐ Donation 5 ☐ Other (Specify) Annapolis, MD 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licens 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition enn Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death g 🗌 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of page 2 autopsy perform death? certificate Yes 2 🗌 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2. No ျ 1 Yes 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1. Natural Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No М Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of cartifier 29c. License number 1 Ctran 21438 Name and address of person who completed cause of death (Item 23a) (Type, Print) HNNAPOLISMD LIYO, DEFENSEHWY E m m 31. Date filed (Mon gistrar's Signature State

Physician/ Medical Examiner

that the death certificate be executed

Box 68760

P.O.

of Vital Records,

Division

Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director,

attending physiciar

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Physician/

Medical

10a, State

MD

Examiner

Funeral

Director

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items 23a

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Page 1 and 2

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Important: If it any injury or o

the Medical

Baltimore, Maryland 21215-0036

Examiner must be notified at

Director

Completed by

Be

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last

Examine burial-transi

Physician/Medical

δ

Completed

Be

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Certificate:

Medical

IF FEMALE 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No g 🗌 Unknown

1 Natural

4 Homicide

Accident Suicide

31. Date filed (Month, Day,

CHRONIC LYMPHOID LEUKEMIA, ATRIAL FIBRILLATION

Registrar's Signature BREAM

AORTIC VALVE DISEASE, HYPOTHYROIDISM ANEMIA, HYPERTENSION

24b. Were autopsy findings available prior to completion of cause of death? autopsy

1 Yes 2 No

L			
	25. Was case referred to medical examiner? 1 Yes 2 No	Ho	spital:
ľ	27. Manne of Death		28a. Date o

5 Pending

determined

npatient 2 DER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of Investigation 6 Could not be

28c. Injury at work? 1 ☐ Yes 2 ☐ No

Other:

26. Place of Death (Check only one)

4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

2 No

Yes

City or Town, State

la. Certifier	1 Certifying Physician: To the

Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

injury

ne best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number,

				, ,			
9b.	. Signa	ture and	file of ce	rtifier	0		0-
		H	nas	1/	Wills:		40
	,	1////	400	1111	DUVY ION	AULION.	ans.

H61505

29d. Date signed (Month, Day, Year) 12

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9710 Hmar luggirala

Poolesville

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dece edent's Name (First, Middle, Last) 2 Date of Death Physician/ Cerrel 15:03 M 201 Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** ltimore If Under 24 Hrs. Age (In vrs. last birthday) If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Min (Month, March Day, Hours 53 Maryland Director 1958 219-68-9144 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Direct 1 Yes 2X No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 23a Funeral 21702 United States 2104 2B Whitehall Road items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ō ò 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Il Hygiene. other than " life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Citizens Nursing Home Nurse Assistant and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Leroy Simms permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Elsie Morrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2104 2B Whitehall Road, Frederick, Maryland 21702 William Gulliford/ Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Stauffer Crematory Inc. 12/19/11 Frederick, Maryland 21. Signature of Juneral Se 22. Name and Address of Facility. Stauffer Funeral Homes P. A. 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the burial-transit Cause (Disease or finjury that initiated events resulting in death) Last and Due to (or as a consequence of) nding physician Physician/Medical death certificate be Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy for in the past 12 months? Month Day Year signed by the at d be detached fo g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Puhmonany Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Distress Syndleme Respiratory 24b. Were autopsy findings available prior to completion of cause of 24a, Was an page 2 autopsy performed? death? certificate Division of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 No Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? hours after death. Ineral Director: A 2 No the 1 Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check To the only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 0 31. Date filed (Month. Day, Year) State

			Amend 19a	Please , per inf end Item I D#19aperINF	Type or Pri	int in B 0/12 T arvland	lack In RT LDeba	idelible In	k. Ens Health	sure A and M	II Copie Iental Hy	s Are	e Legi	ble.	
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and a	Examin		4a. Facility Name (i	not institution, give	street and number)	tosdit	Hal'	4b, Gity, Town, o	Location Milh	of Death	itu	40	c. County	of Death	
	Funeral Director		5. Social Security N 229-93-2	860 1	VIM 2□ E	je (<i>In yr</i> s. <i>I</i> as	t birthday) Yrs.	If Under 1 Year Months Days	If Unde Hours	r 24 Hrs. Min.	8. Date of Bir Month, Da 03/10	ay, Year)	5	Cour	place (State or Foreign htry) ezuela
	/land f show ed at	tor	Usual Residence 10a. State	10b. County		10c. City,	Town or Loc								10d. Inside City Limits
	the Mar or 28a- e notifie	Funeral Director	MD 10e. Street and Nur	Montgome:	ry	ROCK	ville	10f. Zip Code				10g. C	itizen of W	/hat Cou	1 Yes 2 No ntry?
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9	72 hours after death with the Maryland "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	by Fu	11. Marital Status 1 X Never Mari	ried 2 🗌 Married	12. Was Decedent Armed Forces? 1 Yes 2 X			Vas Decedent of H Yes, specify Cuba X Yes 2 No					Black	k, White,	
-003	ours af atural" cal Exa		3 Widowed	4 Divorced	If Yes, Give Year or Dates.			ent's Usual Occup		v. verie	Zuelan	16b k	Specify: Kind of Bu		panic
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	(Spec	ecify only highest gra			(Give I life. D	ind of work done O NOT use retired)	during mo:)				lf Er		
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Maryland	should be fil and Mental is marked or raumatic eve	٩		(D.) 11 (F.)		· I	_			ria G					0(1)
	d 2 sho alth and n 27 is r er traun	100	Performant N	ame/Relationship (Ty CFFCFO SCFFA SIS Oder Guer)	_{pe, Print)} ter rero Gile:	r	19b. Mailin	g Address (Street 16th Str	eet,	#60 7	, Silv	er, City o er S	prine	j, M	D 20910
Baltimore,	ge 1 and nt of Heal r: If item?		20a. Method of Dis 1 Burial 2	position ☐ Cremation 3 🏻	Removal from State	20b. Pla	netery, cren	sition (Name of natory or other pla			Date			•	own, State
altin	permit. Page 1 a Department of H Important: If ite any injury or ot		4	5 ☐ Other (Specify neral Solvice Licens	·	Jaro		. Name and Addre			owden :				l, Tachira
8	De an in o		160	the disease, or comp	MO1576	TALL TO AL		46 N. Wa					lle,	MD	20850 Approximate
	Physician/			rt failure. List only or (Final				HIOU!			ma				Interval Between Onset and Death
C	Medical Examiner		resulting in death)		a. Due to (or as	a cons que	1010)		~VIII					
	- ±0	iner	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or	onditions, mmediate erlying	Due to (or as	a conseque	nce of):								
	executed an and rial trags	Examiner	Cause (Disease or that initiated event resulting in death)	is 🔳	c. Due to (or as	a conseque	nce of):							\dashv	
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. Box	sician: The law requires that the death certificate be certificate has been signed by the attending physicir rector, page 2 should be detached for use as the bu	Completed by Physician/Medica	in the past 12 1 ☐ Yes 2 9 ☐ Unknowr	□ No	4 Pregnant a 9 Unknown			Other (specify)					Мо	nth	Day Year
, P.O.	s that the	by Pl	Part II. Other signi	ficant conditions co	ontributing to death I	but not resul	ting in the u	nderlying cause gi	iven in Par	t I.					the cause of death?
ords	require been s should	leted									24a. Was	s an	24b. \	Vere auto	opsy findings available
Rec	The law ate has page 2	Comp										opsy formed? 2 X 1		leath?	ompletion of cause of
ital	sician: certific irector,	Be	25. Was case referrence examiner?	u: h	Hospital:		2/0.4	26, P at 3 □ DOA Oth	nor:	eath (Check	only one)	internal	e □ Oth	v /Cnaais	5.1
of V	ng Phy fter this	ate: To	27. Manner of Dear	, 1	28a. Date of inju	ury 2	8b. Time of injury	28c. Inju	ry at k?		me 5 L Res 28d. Describe				<u>y</u>
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Certificate:	2 Accident 3 Suicide 4 Homicide	Investigation 6 Could not be determined	28e. Place of Inj	jury - At hom	ne, farm, stre	M 1 L	Yes 2					er or Rura	al Route Number,
Οį	Hospital or 24 hours afte Funeral Directely filled in		29a. Certifier	Certifying Phys			dae death	occurred at the tim	ne date an	nd place, at	City or To			er as sta	ated.
	the Hos thin 24 h the Fun mpletely	Medical	(Check only one)	2 Medical Exami 3 Certifying Nurs	ner: On the basis of e	examination a	and/or invest	tigation, in my opini	ion, death	occurred at	the time, date	and place the caus	ce, and due se(s) and n	to the c nanner as	ause(s) and manner stated s stated.
	20		29b. Signature and	title of certifier	MD			29c. Licens	se number	200		29d. D	ate signed	(Month,	, Day, Year) (o 2011
	\sim		30. Name and add	ress of person who o	completed cause of	death (Item 2	23a) (Type, F	Print) DIG	112	BAH	imore	M	D.	2/2	27
	Sta	te	31. Date filed (Mon		2. Registr	rar's Signatu	re P	VVVIIC	011	DUCT	II I (VIC) !'') 2	-1-	
	Dogiote	0.5	ne.	r 9 1 2011	17		MAL								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 17, 2011 5:00 a M Alexander Wolfgang Geyger Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Sunrise Assisted Living Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Hours 577-58-4071 **Director** 1 🛛 M 2 🗆 F Yrs March 6, 1937 Germany Usual Residence of Decedent 28a-f show aţ 10a. State 10c. City. Town or Location 10d. Inside City Limits with the Maryland Director notified 1 Yes 2 X No Montgomery Silver Spring 10e. Street and Number ò 10g. Citizen of What Country? r items 23a or ner must be n Funeral 11621 New Hampshire Ave, #103 20904 USA death , Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or ite Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. White Specify: 1 Never Married 2 X Married by Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 No Specify: 3 Divorced 4 Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 l. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medicone. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Librarian D.C. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ella Unknown Unknown Geyger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 411 Lexington Drive, Silver Spring, MD 20901 George Bond Baily, Jr/Executor 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State cemetery, crematory or other place) Dec. 22 2011 4 Donation 5 Other (Specify) Metropolitan Crematory Alexandria, VA Signature of Funeral Service Licensee 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 000 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Cardiorespiratoy Arrest disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Lung Cancer Sequentially list conditions. Examine in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence on buriativa To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death g ☐ Unknown be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 🗌 No 3 🗌 Probably 4 🎦 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 2 🗌 No ☐ Yes 2X No 1 🗌 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 H No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 은 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred XNatural 5 Pending work 1 Tes 2 🗌 No within 24 hours after death. To the Funeral Director: A Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day) Year) 10

State Registrar

Jean Welsh, MD

31. Date filed (Month, Day, Year) 82. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10801 Lockwood Drive, Silver Spring, MD 20901

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 18, 2011 9:30a December Cora Mae Henschen /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Lorien Assisted Living Mt. Airy If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🕅 F Yrs. June 30, 1918 93 Pennsylvania Director 167-24-4668 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 XIYes 2 No Director Maryland_ Carroll Mt. Airy 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21771 United States 713 Midway Road 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Saltimore, Maryland 21215-0036 Specify. Specify. 9 3 X Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PSU Registrar 12 Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Ripka Jacob T. McCool 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8492 Tipton Drive, Laurel, Maryland 20723 Robert M. Henschen/ Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 2/23/11 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Centre County Memorial Park State College, PA 21. Signature of Faneral Service Conse 22. Name and Address of Facility
Stauffer Funeral Homes P.A. 1621 Opossumtown Pike, Frederick, Maryland 21702 Approximate Interval Betwe Onset and/De 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-tran (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions copylibuting to death but not resulting in þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an page 2 certificate has autopsy Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director. Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 1 Yes 2 No 2 ☐ ER/Outpatient 3□ DOA Certification: To 6 After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h. Time of 28d. Describe how injury occurred 28c. Injury at 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 24 hours after death 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ca completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medi and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29c. License number ed cause of death (Item 28a) (Type, Print) 8 Registrar's Signature 31. Date filed (Month, Day, Year) 32 State

DHMH 17 Rev 1/2001

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42906 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3*54* Milton Pennell Hill 2011 Medical Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner PONISSULA 144156414 HICOMIC Social Security Number Age (In yrs. last birthday) Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Davs Hours (Month, Day, Year) 219-28-9551 Director 80 1 **X** M 2 □ F 12/06/1931 Maryland show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 X Yes 2 No Virginia Accomack Greenbackville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a or Funeral 1445 Stockton Ave. 23356 USA Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give 1 Yes 2 X No Specify: Specify: White Completed 3 Divorced 4 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 Appraiser <u>Real Estate</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Milton Painter Hill Louisa Boyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha P. Hill/spouse PO Box 3, Greenbackville, VA 23356 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Important: If it 1 Burial 2X Cremation 3 Removal from State Salisbury Crematory Donation 5 Other (Specify) 12/26/2011 Salisbury, MD permit. re of Funeral Service Licensee Siana Polloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 any aire (Hompson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injurithat initiated events resulting in death) Last attending physician and I for use as the burial-tran Due to (or as a consequence of): Physician/Medical death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year signed by the a the Hospital or Attending Physician: The law requires that the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records. 1 Yes 2 No 3 Probably 4 Junknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has performed 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes ပ npatient 2 ER/Outpatient 3 DOA this 27. Mannel 28a. Date of injury Certificate: eath 28b. Time of 28c. Injury at 24 hours after death. Funeral Director: After (Month, Day, Year) 5 Pending atural work?
1 Yes 2 No Accident Investigation filled in by the 6 Could not be

State

the within To the

Registrar DHMH 17 Rev 06-201

Medical

Suicide

29b. Signature and title of certifie

30. Name and address of perso

31. Date filed (Month. Day, Year

determined

4 Homicide

29a. Certifier

(Check

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critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

bury MD

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

n who completed cause of death (Item 23a) (Type, Print)

32

Carroll

egistrar's Signatur

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Month Physician/ Larolyn Willey

4a. Facility Name (if not institution, give street and number, 6 2011 Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Dorchesz -0 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral Davs Min. (Month, Day, Year) **Director** 1 □ M 2 💢 F permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 2/6/3 JA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White Completed | 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Elmer LeRoy Willey 19a. Informant's Name/Relations p (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip ode) 20b. Place of Disposition (Name & 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ussan-Brossers / Funeral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ CANCER ung O YEARS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions. Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trai Due to (or as a consequence of): resulting in death) Last as IF FEMALE signed by the attendin Id be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 1 Yes 2 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy 2 No 1 Yes **Division of Vital** the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Parents Hospital: Other: ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 X Other (Specify Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident injury 5 Pending 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completely filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and 12-19-2011 D39887 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) . Jmith 8221 Teal Drive Easton MA State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Month Hoffacker Irving Percy 2011 Medical December 20 3:20 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Long View Nursing Home Manchester Carroll Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours Min 214-28-5047 89 Director 5/1/1922 MD Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Hampstead 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 21074 907 Clearview Ave. USA items ; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, er than "natural", or iter the Medical Examiner Black, White, etc. þ 1 X Never Married 2 Married 🗌 Yes 2 🔀 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) within 7 Elementary/Seconday (0-12) College (1-4 or 5+) Telemechanique welder Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ပ Ethel LaRue Kelbaugh George Floyd Hoffacker of Health and Mer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 0221, Hampstead, MD 21074 Dennis E. Mitchell, Attny. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 12/23/2011 Hampstead, MD Greenmount UM Cem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Eline Funeral Home Signature of Funeral Service Licensee M00741 fand 934 S. Main Street, Hampstead, MD 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death congestina Physician disease or condition Medical resulting in death) Examiner 9400 Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 🗆 No detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by be 1 ☐ Yes 2 ᡬNo 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 X No Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No Certificate: To 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of Manner of Death 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending injury work' s after death. 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical r Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier соmpleted (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) fan wiga mo 51705 12-20-11 WJL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. PANSURIYA 2111 Hanove Hanover 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** or Location of Death care and W 10H 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 05/22/ **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 F Days Hours Min. Country) **Director** 192Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Deale MD Anne Arundel 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20751 6014 Melbourne Ave 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 1 If Yes, Give 2 X No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: 1 and 2 should be filed within 72 hours aft if Health and Mental Hygiene.
item 27 is marked other than "natural", 3 Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Factory Worker Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Stone Industrial 06 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Sally Mae Allen 2 George Albert Wilburn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6014~Melbourne~Ave.~Deale, MD~20751Betty Scarberry Daughter 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of permit. Page 1 a
Department of IImportant: If ite
any Injury or ot Date 20c. Location - City or Town, State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 12/19/2011 Glen Burnie,MD Atlantic Crematory 21. Signature of Foneral Septice Licenses 22. Name and Address of Facility 12 Ridgely Ave Annapolis, MD 21401 Hardesty Funeral Home P.A. ats 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): Exami Physician: The law requires that the death certificate be executed g physician and is the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical nding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 menths? Year Pregnant at time of death signed by the a d be detached f 1 Yes 2 5 g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy certificate 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 **P**No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred the Hospital or Attending Natural injury 5 Pending after death. 1 Yes 2 No Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signa **DEC 2 0 2011** Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42910 State Registrar Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death Physician/ 0430 M OLMES 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis ear If Under 24 6. Sex If Under 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Months Davs Director 216-78-6354 1 🗆 M 2 🔀 F 54 Feb. 13, 1957 Maryland ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 267 Tolstoy Lane 21146 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 X Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 No Specify Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 7 and Mental Hygiene. 7 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ewonce. 2 Eleanore Fisher Jesse Mays 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Holmes, III/Husband 267 Tolstoy Lane Severna Park, MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State Lakemont Memorial Gardens Davidsonville, MD 4 ☐ Donation 5 ☐ Other (Specify) 2011 22. Name and Address of Facility Barranco & Sons, 495 Ritchie Hwy. 21. Signature of Funeral Service Licensee Severna Park Funeral H Severna Park, MD 21146 P.A. 23a. Part Enter ne disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ mareatu resulting in death) Medical ue to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying
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4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ģ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has autopsy this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No Hospital or Attending Physician: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospita Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, funeral 27. Manner of Death 28b. Time of 28c. Injury at work? s after death.

I Director: After the Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Investigation Could not be filled in by the Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 072360 my

State Registrar ensething ANNApolis Mozicoi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ A UO JM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ANNAPOLIS ANNE ALUNDEL NNE ARUNDER MEDICAL If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Months Hours 89 153-18-9398 **Director** 1 □ M 2 🛣 F Yrs NEW YORK 2/25/1922 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 ☐ No ANNAPOLIS MARYLAND ANNE ARUNDEL 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21403 U. S. A. 302 CEDAR LANE death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: WHITE 3 X Widowed 4 □ Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) 12 HOME HEALTH CARE PROVIDER NURSING other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MARIE KEALY CALVIN SPAFFORD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 302 CEDAR LANE, ANNAPOLIS, MARYLAND CAROL M. LILLY/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗆 Burial 2 ី Cremation 3 🗆 Removal from State cemetery, crematory or other place) Atlantic Crematory 12/17/2011 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) any injury 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ROBERT E. EVANS FUNERAL HOME 116000 ANNAPOLIS ROAD, BOWIE, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MONARY disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-transit The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last ending physician are as the burial by Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy the attenthed in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ₽ 9 ☐ Unknown 9 Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PERIPHERAL VASCULAR DISFASE 2 No Records, 3 Probably 4 Unknown is certificate has been si director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of BREAST CANCER 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medica Division of Vital Hospital or Attending Physician: 26. Place of Death (Check only one) Be examiner? ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death n 24 hours after death.

e Funeral Director: After the oletely filled in by the funeral. 28a. Date of injury 28b. Time of 28c. Injury at work? 1 Yes 2 No 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending iniury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse 3 of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 29d. Date signed (Month, Day, Year) 29b. Signature and 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) pstack Medi State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 42912 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Edward V. Jarmon 11:00AM December 26,201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Ceci incial Security Num Under 24 Hrs Hours Min. 8. Date of Birth (Month, Day, Year) Oct. 22. 1 **Funeral** If Unde 9. Birthplace (State or Foreign 224-20-8933 1 🔀 M 2 🗆 F Months Country) Virginia **Director** 87 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location Director 10d Inside City Limits Examiner must be notified Millersville Marvland Anne Arundel 1 ☐ Yes 2 🗓 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 8123 Foxwell Road 21108 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married and 2 should be filed within 72 hours after i Health and Menta Hygiene. 1 ☐ Yes 2 🕅 No Specify. If Yes, Give Specify: Completed 3 Widowed 4 X Divorced Year or Dates 1943-47Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) unknown Elementary/Seconday (0-12) the unknown Baker unknown Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Elijah Harmon Edith Beckett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 William Harmon (nephew) 1451 North Edwood Street, Philadelphia, PA 19151 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 🏿 Cremation 3 ☐ Removal from State permit. Page 1 a
Department of H
Important: I' ite
any injury or ott 20b. Place of Disposition (Name of 20c. Location - City or Town, State West Chester, cemetery, crematory or other place R.A. Ferris & Co., Inc. 12/27/11 4 Donation 5 Other (Specify) Pennsylvania 21. Signature of Funeral Service License 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death Immediate Cause (Final disease or condition Physician/ Stage Medical resulting in death) Due to (or as a consequent Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 28d. Describe how injury occurred Natural injury 5 Pending 2 🗆 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, TIVA 30. Name and address of person who completed cause of death (Item 26) (Type, Print) VA Maryland 1-tealth Care System, Henry 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBER 25 20°11'1 05:30 AM ELIZABETH M. HENRY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CECIL 344 MARKET STREET CHARLESTOWN 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 1 M 2 X F Hours JULY^{nth}1^{Dqy}, 1918 MARYTAND 232-26-1315 93 Yrs Director Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director XX Yes 2 No MARYLAND CECIL CHARLESTOWN 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 21914 UNITED STATES 344 MARKET STREET items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc.
WHITE 9 <u>م</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", Specify: 3 X Widowed 4 □ Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
AMMUNITY Correling ROCUREMENT
MANAGER 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) UNITED STATES and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ MICHAEL WILLIAMS MARY GALLO 19a. Informant's Name/Relationship (Type, Print) ge 1 and 2 short of Health a DORIS MCDANIEL / FRIEND 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State DECEMBER 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Page 1 injury or CHARLESTOWN CEMETERY Department Important: If any injury or CHARLESTOWN, MARYLAND 30. 2011 CHARLESTOWN, MA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 127 SOUTH MAIN STREET, NORTH EAST, MARYLAND 21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Interval Between Onset and Death

Unbnawn Immediate Cause (Final Physician/ emen disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami and -tran Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be. Division of Vital Records, P.O. Box 68760 the SBS IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes Other: ျပ 2 🗹 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 24 hours after death. 5 Funeral Director: After thi leted filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending work 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 00023322 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 ST, Eletin MD 2/92/

Registrar
DHMH 17 Rev 7/2009

State

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State of Maryland		artment of tificate of			201	1 42914
E		-	Registrar 1. Decedent's Name (First, Middle, Last)	Cer	incate or	Death	2. Date of Dea	Reg. No. ZUI	3. Time of Death
и	Physicia Medio		Feliciano Lopez Huaman				Decembe	r 15 201	i 10:20 a ^M
	Examin	er	4a. Facility Name (if not institution, give street and number) Manor Care Wheaton			or Location of Dea	ath	4c. County of E Montg	
100	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las 218-19-7565 1.7% 2.7 F 94	t birthday)	If Under 1 Year Months Days			h 9. y, Year)	Birthplace (State or Foreign Country)
	Director		218-19-/565 1 □¾ 2 □ F 94 Usual Residence of Decedent	Yrs.			June 9,	1917	Peru
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	e Mar r 28a- notifii	Dìre	Maryland Montgomery Sil	Lver S	10f. Zip Code			10- Citizen of Mine	1 Ves 2 No
	s 23a o	Funeral Director	2509 Jennings Road		2090)2		10g. Citizen of What Peru	
21215-0036	Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	If	Vas Decedent of I Yes, specify Cub	an, Mexican, Pue	Specify Yes or No- rto Rican, etc.) ⊇ruvian	14. Race - A Black, V Specify:	American Indian, Vhite, etc. White
15-(72 hou "nat	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occu ind of work done	during most of w	orking	16b. Kind of Busin	ess/Industry
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e, N	and 2 Health em 27 ther tr		Delfina Pelaez Lopez / Wife 20a. Method of Disposition			ŗ		ring, MD	
mor	age 1 sent of h		1 X Rurial 2 Cremation 3 Removal from State Cer	metery, crem	sition (Name of natory or other pla eaven Ce	metery	cember 21, 2011	20c. Location - City Silver S	pring, MD
Baltimore,	permit. Page Department o Important: If any injury or once.		21. Signature of Funeral Service Licensee	F ²²	Name and Addr	ess of Facility n	s Funeral	Home, In	c. ring, MD 20901
Į.			23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.						Approximate Interval Between
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1	Medical Examiner		resulting in death) Due to (or as a consequence) The second of the sec	nce of):					
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	icate be executed physician and to the burial trans		resulting in death) Last Due to (or as a consequent	nce of):					
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Box 68760	ending r use a	an/N	IF FEMALE: 23b. Was decedent pregnant in the part 12 months? 23c. If yes, outcome of pregnanc	oy death 3 □	Ectopic pregnar	ncv		23d. Date o	-
	that the death certific	Physician/M	in the past 12 months? 1 Yes 2 No		Other (specify)			Month	Day Year
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Division of Vital Records,	To the Hospital or Attency within 24 hours after death To the Funeral Director. Completely filled in by the		4 Homicide determined 28e. Place of Injury - At hom building, etc. (Specify)				City or Tow	n, State)	Rural Route Number,
	e Hosp 124 hor e Fune bletely f	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my knowled (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowled	and/or investi	gation, in my opin	ion, death occurre	d at the time, date a	nd place, and due to	the cause(s) and manner stated.
	To the writhin	-	29b. Signature and title of Gertifier	-331	29c. Licens	se number		29d. Date signed (M	
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			30. Name and address person who completed cause of death (Item 2 Oney Zuniga, N	3a) (Type, Pi 1D 4	701 Rand	dolph Ro	ad, Rocky	ville, MD	20852
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Physicia /Medic	_	Raul	Ramir	ez Jimenez					Decembe	er 20,	2011	1:07p M
Examin		4a. Facility Name (/	f not institution,	give street and number,)			or Location of Death		4c. Cou	nty of Dea	th
Funeval	2:	5. Social Security N			ge (In vrs.	last birthda	y) If Under 1 Year		8 Date of Birt	h	tgome 9. Bir	ery thplace (State or Foreign
Funeral Director		214-75-	8083	1 ∑ M 2□F	99	Yrs.	Months Days	Hours Min.	NOV 3,	y, Year) 1912	Mex	ico
and w		Usual Residence of 10a. State	Decedent 10b. County		10c. Cit	y, Town or	Location					10d. Inside City Limits
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status1 □ Never Marr3 ☒ Widowed		12. Was Decedent Armed Forces' 1 ☐ Yes 2 ☐ If Yes, Give A Year or Dates:	?	.S. 13	3. Was Decedent of If Yes, specify Cu 12 Yes 2 □ No	Hispanic Origin? (Span, Mexican, Puert Specify: Mex			Black, Whit	erican Indian, le, etc. icasian
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Physician /Medical Examiner	Examiner	23a. P. in Ent of ck, or a limmediate Cause (disease or condition resulting in death) Sequentially list confirmed in the cause. Enter Under Cause (Disease or that initiated events resulting in death)	art failure. List of Final on the conditions, namediate orlying injury s	a. CARDIA Due to (or as b. ATHERO Due to (or as c. HYPERT Due to (or as	Ine. C ARE S a conseq SCLER S a conseq ENSIO	EST uence of): OTIC uence of):	HEART DIS		cor respiratory a	rrest,		Approximate Interval Between Onset and Death 10 MINUTES YEARS YEARS
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ital or Att urs after de ral Directe	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	ned 28e. Place of in building, e	tc. (Specif	y) 	street, factory, office		City or To	wn, State)		Rural Route Number,
the Hosp in 24 hou the Fune	Medical	29a. Certifier (Check only one)	2 Medical E	Physician: To the best examiner: On the basis and manners	of examina		investigation, in my	opinion, death occu		date and pla	ace, and du	ue to the cause(s)
To To COUT	2	29b. Signature and	title of certifier	0)				nse number				nth, Day, Year)
,		30 Name and adds	ress of person "	who completed cause of	death (Iton	n 23a) /Tvn		0609		12/20	7/201	L
				D., 10810 D.	ARNES	TOWN	ROAD, #20	2, GAITHE	ERSBURG,	MD 20	878	
Sta Registra		31. Date filed (Mon	oth, Day, Year) C 2 2 2	32 Regist	rar's Signa	ature 4	wed.				-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ĬŎ, December 2011 С. 6:15 AMM Maurita Jenkins Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice of Howard County Columbia Howard If Under 1 Year If Under 24 Hrs. Social Security Number Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Yea Jan. 29, Months Days 578-34-7776 83 Director 1 □ M 2 🛣 F 1928 VA Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Funeral Director must be notified 1 Yes 27 No MD Howard West Friendship 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 23a 2730 Route 32 21794 items 2 . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 9 by 1 Never Married 2 Married 1 ☐ Yes 2 🗶 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify Specify: "natural" Completed 3 Widowed 4 X Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.

27 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 12 Administrative Assistant Clerical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ John M. Sheppard Esther M. Gross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. James M. Jenkins, Jr. (Son) 11920 Mekenie Court, Marriottsville, MD 21104 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Mt. View Cemetery 12/14/2011 Marriottsville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA Blian Ha MOO 764 laut PO Box 195 Sykesville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Ovarian months disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? ō Month Day Year Pregnant at time of death signed by the at d be detached for g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an sate has page 2 s performed' certificate 1 Yes 2 No 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOS DICE 1 ☐ Yes 2 ☑ No ပု 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 To the Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) WSL D0060634

Registrar

State

CEDAR L

COLUMBIA MD ZIOHH

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6336

32. Registrar's Signature

JUSEPH

BINDU

31. Date filed (Month, Day, Year)

Ame	nd #18 g	er	FD pt. _{F3} 2-22-11 F		Type or Pri State of M								egible.	
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			Registrar 1. Decedent's Name (Fig. 1)	irst, Middle, Last)				rincare	0, 2	Cati	2. Date of De	Reg. No.		3. Time of Death
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marge (198 Boon	es Drive				Lot	hian	1		Anne	e Arund	del .
	Funeral		Social Security Number	ber 6. Sex	7. Ag	e (In yrs. Ia	st birthday)	If Under 1 Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th y, Year)	g. Birth Cour	place (State or Foreign ntry)
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36	after c	b	1 Never Married		1 ☐ Yes 2X☐ If Yes, Give	No		1 Yes 2						nite
21215-0036	ours atural	Completed by	3 ☐ Widowed 4X	5. Decedent's Edi	Year or Dates.			dent's Usual	Z1			16b Kind	of Business/Ir	
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<u>ylaı</u>	d be Menta arked	일	Clare			New	combe			Marjo	rie Cl	<u>ark</u>		
Maryland	shoul and is m		19a. Informant's Name							nd Number or Rur				Code)
2	and 2 dealth am 27 her to		Paul D. J		ormer Spo	_				Millsbo				Faura Chata
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			Cremation 3 1	Removal from State	C	emetery, cre	osition (Name matory or oth es Cem	her place	a) i	Date . 9/2011		tion - City or T ian , MD	own, State
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ί	Physic this c	은	1 Yes 2 2	No .	1 Inpat		ER/Outpatie	ent 3 DO	Bc. Injury	4 L Nursing H	ome 5 Res			fy)
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Sio	Attendii death. ctor: Ai cy the fu	Certificate:	2 Accident 3 Suicide 4 Homicide	Investigation Could not be determined	28e. Place of Inj	ury - At ho	me, farm, st				28f. Location	Street and N	umber or Rur	al Route Number,
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_	e Hospital or Attending Physician: The law requires that the death certificate be 1/21 hours after death. Funeral Director. After this certificate has been signed by the attending physicial Funeral Director. After this certificate has been signed by the attending physicial letely filled in by the funeral director, page 2 should be detached for use as the bu	Medical	29a. Certifier 1 (Check 2	Certifying Physi	ician: To the best of	my knowl	ledge, death	occurred at	the time	e, date and place, a	and due to the cat the time, date	cause(s) and and place, ar	manner as sta	ated. ause(s) and manner stated.
	To the Hosp within 24 ho To the Fune completely f	Me	only one) 3	Certifying Nurse	e Practitioner: To th	ne best of n	ny knowledg	e, death occu	irred at th	he time, date and p	lace, and due to	the cause(s)	and manner as	s stated.
	5 Vit		29b. Signature and title		· Tree	00	100	290.		number D263	77		signed (Month)	
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(141		30. Name and address	Surperson who co	del M.D.	leain (Item	79 C	5/2 5	501	ovens	In	Ed,	Muy.	lie prop
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month / 2 Year Physician/ 6:39 ARY 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Annapolis 1323 Harbor Road Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday, Funeral Months Hours 1 □ M 2**X**□ F Director 223-44-9980 11/10/1927 West Virginia 84 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director Annapolis 1 Yes 2 X No Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21401 23 Collison Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo Black, White, etc 9 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 🕅 Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than " Elementary/Secondary (0-12) College (1-4 or 5+) Service Station Bookkeeper Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Veda Richards James Craft injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1323 Harbor Road, Annapolis, Maryland 21403 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or are Betty Ann Bryant/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)

Lakemont Memorial Gardens 12/23/2011 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Davidsonville, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature uneral 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final ANCRENTIC Physician/ montes disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examir attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 \(\sum \) Yes 2 \(\sum \) No Month Year Day 5 Other (specify) Pregnant at time of death been signed by the a should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy filled in by the funeral director, page 2 performed' To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 1 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) Daughter's 1 Yes ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 Yes 2 No Home 27. Manner of Death 28d. Describe how injury occurred Certificate: 5 Pending Natural Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check 3 only one) 29b. Signature and title of cert 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

DEC 21

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Amend Item 25 State of Maryland / Department of Health and Mental Hygiene per me,g923,01/30/2012dhb Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 7.01A M 2011 Joyce Evangeline Tate Jackson Dec. 16, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bethesda MOntgomery Suburban Hospital If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1 🗆 M 2 🔀 F Months Davs Hours (Month, Day, Year) April 27, New York 050-46-8949 **Director** Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No M Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 14900 Emory Lane 20853 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔼 No Black, White, etc. African-Specify: America Completed by 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 🏝 Divorced Year or Dates. American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Executive Non- profit Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Joseph Tate Susan Bowling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 418 Missouri Ave. NW Washington, DC 20011 Daaron Jackson/ son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Cemetry 12/23/11 Rockville, Md . Signature of Funeral Service Licenses 22. Name and Address of Facility McGuire Funeral Service INC 7400 Georgia Ave. NW WAshington. DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician a. Hyperpyrexia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Quadriplegia Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): EXAMINER signed by the attending physician and d be detached for use as the burial-ransit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending nhusician and Cause (Disease or iinjury Gastrointestinal tube feeding that initiated events resulting in death) Last JON APPROVED BY CLE Due to (or as a consequence of) Physician/Medical CERTIFICAT Diabetes mellitus Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year 5 Other (specify) Pregnant at time of death 9 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, History of deep vein thrombosis on anticoagulation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available History of subdural hematoma; History of cerebrovascular 24a. Was an autopsy prior to completion of cause of death?

1 Yes 2 No accident; Seizures Yes 2X No of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 22 14 Certificate: To 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1X Natural injury 5 \square Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 🗆 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DIME

D20274

12/19/2011

11-09751 Maryanna King

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Certificate	of Death		2 U I j. No.	1 4276
Physici ledical Exam				Date of Death Month December	Day Year 2 4 , 2011	3. Time of Death 1959 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat		4c. County of Death	
Funeral		Prince George's Hospital Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Cheverly y) If Under 1 Year If Under 24Hr	s 8 Date of Right	Prince George	
Director		219-94-8267 1 M 2 Z F 43 Usual Residence of Decedent	Yrs. Months Days Hours Mi		Foreign	
any		10a. State 10b. County 10c. City, Town or L	ocation	···-		10d. Inside City Limits
laryland :8a-f show at once	0	DC Washing	ton, DC			1 Yes 2 No
215-0036 be filed within 72 hours after death with the Maryland mal Hygiewich man after death with the Maryland riced other than "natural", or items 23a or 28a-f abe ent, the Medical Examiner must be notified at once	Director	10e. Street and Number 2426 15th Place SE #102	10f. Zip Code 20020		D. Citizen of What Coun	
eath with items 23	Funeral	1 Never Married 2 Married Armed Forces?	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert		14. Race - Americ White, etc.	can Indian, Black,
after de al", or	by Fu	3 Widowed 4 Divorced If Yes 2 No	Yes 2 No specify:		Specify: Bla	ck
hours a	ed b	15. Decedent's Education (Specify only highest grade completed) 16a. Dec	edent's Usual Occupation (Give kind of ng most of working life. DO NOT use re		16b. Kind of Business/Ir	ndustry
1036 Athin 72 ene.	Completed	12th College (1-4 or 5+)	nemaker		self-empl	oyed
21215-0036 und be filed within 72 hou lonental Hygiene. marked other than "na; ic event, the Medical Ex	Be Co	17. Father's Name (First, Middle, Last) Charles Homer King Jr.	18.Mother's Nam Joanne	e (First, Middle, Ma Davis	aiden Surname)	
	ဥ		ailing Address (Street and Number or Clopper Rd #B			
e, MD I and 2 sho Health and item 27 is		20a. Method of Disposition 20b. Place of Di	sposition (Name of cemetery,		20c. Location - City or	
Baltimore, eemit. Pages I and Department of Heal Important: If iten		4 Donation 5 Other Specify: Chesap	orotherplace) eake Crematory			
Baltimore, MD 21 permit. Page 1 and 2 should Department of Flealth and Me Important: If item 27 is ma injury or other traumatic ex		21. Signature of Funeral Service Licensee	22. Name and Address of Facility $_{ m WH}$ $_{ m 447}$ $_{ m 14th}$ St $_{ m NW}$	Bacon I	Funeral H	ome
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not en failure. List only one cause on each line.				Approximate Interval Between Onset and
Examiner			cations of Sickle	Cell Dis	sease	Death
	_	Sequentially list conditions, if any, leading to immediate b				
0	Examiner	(Disease or injury that initiated				
and and transit		events resulting in death) Last Due to (or as a consequence of): d.				
760, cate be exec physician a he burial - 1	Medical	▼ UNPENDED	per me,g924 2-15-	12 sm		
8760, rtificate be ing physic as the bur	_	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pregn	ancy	23d. Date of delivery Month D	ay Year
Box 68760, he death certificate be executed the attending physician and the for use as the burial - trans	Physician	1 Yes 2 No 9 Unknown 9 Unknown 1 Unknown	Other (Specify)			
S, P.O. E		Part II. Other significant conditions contributing to death but not resulting in			acco use contribute to t	
LS, P quires t en sign	ted b	Cocaine Use; Cirrhosis of the live	er	1 Yes 24a. Was ar	2 No 3 Prob	
Division of Vital Records, rad of Attending Physician: The law require and or after dear after dear After this certificate has been sitled in by the funeral director, page 2 should be	Completed by			autopsy perform	prior to co ned? death?	opsy findings available ompletion of cause of
I Re		25. Was case referred to medical	26.Place of Death (Check	only one)	No 1 🗸 Yes	s 2 No
Vital bysician:	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpa			esidence 6 Other:	
n of Viding Physich. After this funeral dir	Du:	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day,Year) 28b. Time	e of Injury 28c. Injury at Work?	28d. Describe ho	w injury occurred	
risio r Atten er deatl rector:	īcati	2 Accident Investigation 28e Place of Injury - At home, farm		28f. Location (St	reet and Number or Rur	al Route Number, City
Div pital or ours aft inled ir	Certification:	4 Homicide determined (Specify)		or Town, Sta	ite)	
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: /	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death of the basis of examination and/or investigation.				
- D-ND	Me	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Mon	th, Day, Year)
1-PEND		D-"UL-	O.C.M.E.		December 29, 20	11
		Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD	900 W. Baltimore Street, Baltin	more, MD 212	23	
S	ate	31. Date filed (Month, Day, Year) JAN 0 5 2012				
Regis	rair	JAN 0 5 2012 Review A. A.	-			

OUNE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month 3 3:10AM Physician/ Dennis G. Keane Medical 4c. County of Death Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** SO the 200 Wicomico 14090100 04 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs 8. Date of Birth Age (In yrs. last bi **Funeral** Aug. 28, 1947 1 😾 M 2 🗆 F Months Virginia 217-44-9905 64 Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director 1 X Yes 2 □ No Marvland Worcester Berlin 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō er than "natural", or items 23a on the Medical Examiner must be Funeral United States 21811 11645 Maid At Arms Lane 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 X No Black, White, etc. and Mental Hygiene.
is marked other than "natural", or 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Police Officer Law Enforcement Dennis injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, permit. Page 1 and 2 should be file.
Department of Health and Mental H.
Important: If item 27 is marked any injury or com-ည Ann Elizabeth Miller James Keane 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11645 Maid At Arms Lane Berlin, Maryland 21811 Virginia Keane -wife 20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 12/22/2011 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Alexandria, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Bonald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, Maryland20705 on 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to r as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlyin Examiner Due to (or as a consequence of): TEN C Cause (Disease or linjury that initiated events resulting in death) Last a ending physician and Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be P.O. Box 68760 as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death signed by the at endir 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) Month in the past 12 months?

1 Yes 2 No Day Year 4 Pregnant a Pregnant at time of death the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Division of Vital Records, Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has performed 1 🗌 Yes 😢 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Be examiner? Other: 4 Nursing Home 5 Residence No Hospital: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No injury Natural 5 Pending Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatule and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 63199 12/17/11 Name and addless of person who completed cause of death (Item 23a) (Type, Print)
10 GESU VOHRA 9 IN EASTERN SHORE DR. SALISBURY, MD. 21804. VOHRA

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

DEC 2 1 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) December 20, 2011 6:06 a Physician/ M. Gertrude Lawrence Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carroll Lorien Nursing & Rehabilitation Ctr Tanevtown if Under 1 Year | if Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Funeral Month, Day, Year) 9<u>28</u> Days 1 □ M 2 😿 F Marviand 213-24-8432 83 Aug Director Usual Residence of Decedent show 10d Inside City Limits 10c. City, Town or Location 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at Director Westminster 1 Yes 2 No Carroll Maryland 10a, Citizen of What Country? 10e. Street and Number 10f Zin Code Funeral 21157 102 Timber Ridge Drive USA death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 72 hours after white 1 ☐ Yes 2 X No Specify: If Yes, Give "natural" 3 Widowed 4 Divorced Completed Year or Dates. the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Medical Clerk/Receptionist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Grace Little Herbert Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1679 Beech Lane, Hanover, PA 17331 Charles Lawrence, Jr, son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Green Place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 12/21/2011 Winfield, MD Carroll Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 re Funeral Service Lice is 22. Name and Address of Facility 21. Signa 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exami and burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical death certificate be Box 68760 the as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 - Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Month in the past 12 months?
1 Yes 2 No Day ō Pregnant at time of death i signed by the a ber 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed 2 🗌 No 1 T Yes this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director. After this certifica completed filled in by the funeral director, to Division of Vital 25. Was case referred examiner? 26. Place of Death (Check only one) Be Other: 4 Mursing Home 5 Residence 6 Other (Specify) 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1
Yes ည 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 27. Manney of Death 28c. Injury at 28d. Describe how injury occurred iniurv work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending ☐ Accident Investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier H0061206 WJL 30. Name and address of person who completed Poole Rd. Westninster MD 21157 6

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

DEC 2

32.0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 17,2011 Margaret Lombard 9:00 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** May 30 1 🗆 M 2 🍱 F Hours Min. 84 Yrs Director Massachusetts 221-16-5822 1927 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director or 28a-f st notified 1 Yes 2 X No Maryland| Anne Arundel Harwood 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Completed by Funeral 414 Lankford Road USA 20776 iral", or items 2 Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?
1 Yes 2 X No Black, White, etc. 1 Never Married 2 3 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: White "natural" 3 Widowed 4 Divorced nd Mental Hygiene. marked other than "natur matic event, the Medical I 15 Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ f Health and Ment item 27 is marked other traumatic Robert Beatson Mary Clyne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theodore E. Lombard / Husband 414 Lankford Road, Harwood, Maryland 20776 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ott once. Date 20c. Location - City or Town, State cemetery, crematory or other place)
Our Lady of Sorrows Cem. 1 🛚 Burial 2 🗆 Cremation 3 🗆 Removal from State 12-21-2011 4 ☐ Donation 5 ☐ Other (Specify) West River, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Finer 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death) neumonia Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): death certificate be executed Cause (Disease or linjury ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Other (specify) Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown 9 Unknown the Hospital or Attending Physician: The law requires that the chin 24 hours after death.

the Funeral Director: After this certificate has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗵 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 X No 1 Yes 2 No completed filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ဂ္ 1 Yes 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury Natural 5 Pending Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Howell

DEC 21

31. Date filed (Month, Day, Year)

2031

Annapolis MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

17 per FH State of Maryland / Department of Health and Mental Hygiene 2011

2011 AACO HEALTH DEPT. ONH Contificate of Death Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 15^{ay} 201^Y Pau1 Linden Lewis 11:25amм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Laurel Regional Hosptial Laure1 Social Security Number **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)

Thi 1 X M 2 D F Months Days Hours Min. Director 12/21/1930 410-44-1669 80 TN Usual Residence of Decedent items 23a or 28a-f shov er must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince Georges Laurel 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 318 Prince Georges Street 20707 USA 12. Was Decedent Ever in U.S. korean ural", or iten I Examiner r 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 2 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or any Injury or other traumatic event, the Medical Examin If Yes, Give War Year or Dates. Army 1 Yes 2 No 3 Divorced Completed Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8th Steel Worker Thompson Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Frank Lewis Lewis Mary Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Dorothea H. Lewis</u> 318 Prince Georges St. Laurel, Md. 20707 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Atlantic Crematory 12/18/2011 Glen Burnie, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Robert E. Evans Funeral 22. Name and Address of Facility M00544 16000 Annapolis Road Bowie, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death

3 days Physician, disease or condition Gastrointestinal Hemorrhage Medical resulting in death) Due to (or as a consequence of) Examiner <u>Arteriosclerotic Vasculer Disease</u> 10 yrs Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Day Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 🗌 No 3 🗌 Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? 1 Yes 2 No 1 🗌 Yes 2 😾 No 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 Yes 2 X No မ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury

Hospital or Attending Physician; The law requires that the death certificate be executed attending physician Division of Vital Records, P.O. Box 68760 the s been signed by should be detact cate has bage 2 s this certificate

death with the Maryland

21215-0036

Baltimore, Maryland

Certificate: work? 1 ☐ Yes 2 ☐ No n 24 hours and he Funeral Director. Aft 2 Accident Investigation 6 Could not be Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 **To the I** 29b. Signature and title of certifier D22966 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas H. Burguires, M.D. 7300 Van Dusen Road Laurel, MD 20707 31. Date filed (Month, Day

State Registrar

32. Registrar's Signature

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12 Nicholas Luzetsky, Sr. 2011 3:50 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Ceci1 Elkton Care and Rehabilitation E1kton Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 XM 2 | F Months Hours (Month, Day, Yea, 5/1/1926 Director 220-20-6129 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d, Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 X Yes 2 No MD Ceci1 Cheaspeake City 10e, Street and Number 10g. Citizen of What Country? Funeral 164 Boat Yard Road 21915 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☎ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Specify: "natural", 3 🖾 Widowed 4 🗆 Divorced Completed White Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ed other than " event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) unt of Health and Mental Hygiene.

E: If item 27 is marked other that or other traumatic event. 12 Commercial Painting Union Painter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Alexander Luzetsky Martha Yanvk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21915 Frances Bliss - daughter 504 N. St. Augustine Road, Chesapeake City, MD 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) St. Rose of Lima Cem. 12/30/2011 Chesapeake City, MD Signature of Funeral S Censes 22. Name and Address of Facility R.T. Foard Funeral Home, PA 318 George Street, Chesapeake City, MD 21915 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failu Immediate Cause (Final Physician/ Unbnusz resulting in death) Medical Due to (or as a consequence of) Examiner Unknavn Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence) and that initiated events resulting in death) Last Due to (or as a consequence of): burial-1 attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be e within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Day Pregnant at time of death ed by the a detached f 2 No 1 | Yes 2 L 9 | Unknown 9 Unknown this certificate has been signed by a director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 1158W28 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 No Hospital Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending 1 Natural 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ertifier

State Registrar

TIVA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 8:31AM Diane Dec Medical 4b. City, Town, or Location of Death 4c. County of Death 1a. Facility Name (if not institution, give street and number) **Examiner** Prince Georges Cheverly Georges HOSPITO If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min (Month, Day, Year) 219-64-5136 Director 1 - M 2 V 61 or 28a-f show 10d. Inside City Limits 10h County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at Director 1 Tes 2 No 10e. Street and Number 10g. Citizen of What Country? 23a Funeral be filed within 72 hours after death with ental Hygiene. Anacostia 20019 united items 14. Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status ŏ Completed by 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black Specify: "natural", 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT uses the life DO NOT uses the life of the l (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) rivate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Franklin Klease permit. Page 1 and 2 should ! Department of Health and Me Important: If item 27 is marl 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Capito Heights MD ong Franklin-Itaskins injury or other Important: If item any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Heritage Cemeter Dec 23,2011 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Lice 32 GA. 22. Name and Address of Facility reviesis Crem. And tuneta 300N 23a. Part 1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as carding or respiratory arrest Approximate shock, or heart failure. List only one cause on Interval Between Onset and Death Immediate Cause (Final disease or condition Phomocian/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed (or as a consequence of) burialattending physician I for use as the buris Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 No Day Pregnant at time of death the be detached Unknown g Unknow P.O. signed by 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy page 2 within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No Yes completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: မ 💢 Inpatient 2 🗌 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending 2 No Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 🕽 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 5

Registrar
DHMH 17 Rev 06-2011

State

30. Nam

pmpleted cause of death (Item 23e) Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Amend #5, 1-	State of 1 -3-2012,]	Maryland per FH	d / Depa DR, Œ	rtment of F	lealth and l Death	Mental Hy	giene Reg. No. 2 (42927
			Decedent's Name (First, Middle, La	ast)					2. Date of De Month	ath	Voor	3. Time of Death
	Physicia Medic		Jam	es A. Mul	roe Jr	•			Decemb	er 21 2	2011	6:12 A ^M
	Examin	er	4a. Facility Name (if not institution, giv				4b. City, Town, or		1	4c. County		
	Eunoval		2530 Kensington 5. Secial Security Number 6.		#306 Age (In yrs. Ia	st birthdav)	If Under 1 Year	tt City If Under 24 Hrs.	8. Date of Bir	HOW a		lace (State or Foreign
	Funeral Director		J19 J4 042/	1 ∑ M 2 □ F		Yrs.	Months Days	Hours Min.	(Month, Da	y, Year)	Count	ry)
	T OM		Usual Residence of Decedent 10a. State 10b. County		70	Town and an			July 1	9, 1941		nington DC Od. Inside City Limits
	ırylanı a-f sh ïed a	Director		-		, Town or Loc						1 Yes 2 XNo
	he Ma or 28a notif		MD Howar 10e. Street and Number	<u>a</u>	ETT	icott	10f. Zip Code			10g. Citizen of 1	What Coun	
	with t	Funeral	2530 Kensington	Gardens	#306		2104	3		United	l Stat	es
	death items ner m		11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U.S		Vas Decedent of Hi Yes, specify Cuba			14. Rac	e - Americ	an Indian,
36	filed within 72 hours after death with the Maryland tal Hygiene. So of their than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 Tes 2	X No	1	☐ Yes 2 🔀 No	Specify:		Specify		
21215-0036	hours natura ical E	Completed	15. Decedent's		·		ent's Usual Occup			16b. Kind of B		
215	in 72 le. e. nan "r	duic	(Specify only highest of Elementary/Secondary (0-12)	rade completed) College (1-4 c	or 5+)	life. DO	ind of work done of NOT use retired)		rking	Central	Inte	elligence
2	d with lygien ther th	Be Co		5+		Fan	ancial O				ncy	
Maryland		To B	17. Father's Name (First, Middle, Last, James A. Muroe,		A 1	W-1	C	18. Mother's Nat Pearl A		Maiden Surnam	e)	
ary	should be file and Mental I 7 is marked o raumatic eve		19a. Informant's Name/Relationship		es A.		g Address (Street a			er, City or Town, S	State, Zip C	code)
_	2 ± 2 ±		Rose Mary Mulroe	/Wife		2530	Kensingt	on Garde	ns #306	Ellicot	t Cit	y, MD 21043
ore	0		20a. Method of Disposition 1 → Burial 2 ☐ Cremation 3	Removal from Sta		ace of Dispos emetery, crem	sition (Name of natory or other plac	:e)	Date	20c. Location	- City or To	wn, State
altimore,	permit. Page Department o Important: If any injury or once.	Ų	4 Donation 5 Other (Spec	cify)	Gat		leaven Ce		28-2011			
Ba	permit. Page Department Important: I any injury o	- 1	21. Signature of Funeral Service Lice	nsee	0		Name and Addres					ly FH Inc.
			23a. Part 1. Enter the disease, or con								20,7	Approximate
	Physician/	ş	shock, or heart failure. List only Immediate Cause (Final disease or condition		NTLE	Call	Lympha	······		5 yeu	45	Interval Between Onset and Death
	Medical Examiner		resulting in death)	a	as a consequ		- The little	, , , , , , , , , , , , , , , , , , ,		, , ,		
	LAGITITICI	er	Sequentially list conditions,	b.	as a nonsequ	ores of					-	
	red	Examiner	cause. Enter Underlying Cause (Disease or injury	0110101010	28-2-104-98141	enderoty:						
	execu an and rial-tra		that initiated events resulting in death) Last	Due to (or a	as a consequ	ence of):						
09	death certificate be executed ne attending physician and ed for use as the burial-transit	dical		d								
687	ertifica ding pl	/Me	IF FEMALE:	23c. If yes, outcon	ne of pregnar	ncv				001.0		
Box (ath ce attend	cian	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		h 2 🗌 Fetal	death 3	Ectopic pregnand Other (specify)	У			ate of delive onth	Day Year
B	the de by the ached	Physician/Me	g Unknown	g 🗌 Unknow	rn							
P.0.	The law requires that the death certifica rate has been signed by the attending page 2 should be detached for use as	by	Part II. Other significant conditions	contributing to deatl	h but not resu	ulting in the u	nderlying cause giv	ven in Part I.				e cause of death?
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000	law has	mple							24a. Was auto	DSV	Were autor prior to co death?	osy findings available mpletion of cause of
ž	sician: The certificate irector, pag		25. Was case referred to medical	1			00 01	ace of Death (Che	1 🗌 Yes		1 🗌 Yes	2 🔀 No
/ita	/sicial	To Be	examiner?	Hospital:	atient 2 🗆	EB/Outpatien	Othe	or.		dence 6 🗆 Oth	er (Specify)
of	ng Phy ter this neral		27. Manner of Death	28a. Date of i		28b. Time of injury	28c. Injury	y at	1	how injury occur		
on	tendir leath. :or: Af the fu	Certificate:	1 Natural 5 ☐ Pending 2 ☐ Accident Investigati 3 ☐ Suicide 6 ☐ Could not	on he			M 1 🗆	Yes 2 No				
Division of Vital Records,	pital or Attending Physician: ours after death. eral Director: After this certific filled in by the funeral director,	Cert	4 Homicide determine	⊿ 28e. Place of l	Injury - At hor etc. (Specify)	me, farm, stre	et, factory, office		28f. Location (City or To	Street and Numb wn, State)	er or Rural	Route Number,
Ω		ical		ysician: To the best								
	To the Hos within 24 h To the Fun completely	Medical		miner: On the basis ourse Practitioner: To								use(s) and manner stated. stated.
_	To the I within 2 To the I сотре		29b. Signature and title of certifier	1) (1)	11.	.)	29c. License			29d. Date signe		
			1 lichelas /2t	Williel	Ju II		1 -	38509		Dec. 2	1, 20	11
_	, D		30. Name and address of person who Nicholas Kout				rint) :le Patux	ent Pkwy	Colum	bia, MD	2104	1
	Stat	e	31. Date filed (Month DEC 22		strar's Signati		arke					
	Registra	ar _	420 4 4 i		The state of the s	Feet , 769 19	Calle Pro					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ George A. Mascarich December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 917 Colony Drive Wicomico Salisbury 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days Months Hours (Month, Day, Year) **Director** 112-28-9166
Usual Residence of Deced 1**X**] M 2 □ F 76 Yrs 10/05/1935 10c. City, Town or Location Director 10a. State 10b. County or 28a-f st notified Maryland Wicomico Salisbury ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be by Funeral 23a 917 Colony Drive 21804 USA is marked other than "natural", or items is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No 1 Never Married 2 Married 1 Yes If Yes, Give within 72 hours after Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Purchasing/Transportation Telecommunications other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 George Mascarich Regina McCune 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doriot Mascarich/Daughter e 1 and 2 si of Health a If item 27 i 7724 Asterella Ct., Springfield, VA 22152 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If i any injury or o 1 Burial 2 X Cremation 3 Removal from State 12/27/2011 Salisbury, MD 4 Donation 5 Other (Specify) Salisbury Crematory Signature of Funeral Service Licenses Hoffoway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final an Citatic Physician/ disease or condition resulting in death) Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) The law requires that the death certificate be executed for use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown been signed by the s should be detached g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, Completed 24a. Was an page 2 s autopsy performed of Vital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one, examiner? Other: 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 5 \square Pending 1 🗹 Natural Division s after death. 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours af To the Funeral D Medical 29a. Certifier completely (Check only one 29b. Signature and e of certifier erson who completed cause of death (Item 23a) (Type, Print)

23d. Date of delivery Month 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) MD. 31. Date filed (Month, Day, DEC State Registrar ORIGINAL

42928

3. Time of Death

1:53

9. Birthplace (State or Foreign

10d. Inside City Limits

Interval Between Onset and Death

1 Yes 2 X No

New Jersey

2011

Black, White, etc.

White

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 8:10 A- M Decomber Meushaw 2011 eresa Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Taneytown 134 Saddletop Drive If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Days Months Hours Mary land Yrs. 62 Director 212-52-3820 1948 Usual Residence of Decedent 28a-f shov 10a. State 10b. County notified at 10c. City, Town or Location 10d, Inside City Limits Director Taneytown Carroll Maryland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? "natural", or items 23a o Funeral 21787 72 hours after death with 134 Saddletop Drive USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: white 3 Widowed 4 Divorced Completed d 2 should be filed within 72 hours a alth and Mental Hygiene.

127 is marked other than "natural straumatic event, the Medical Extraumatic event, 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Church of the Elementary/Seconday (0-12) College (1-4 or 5+) Brethren Administrative Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Marian Fodel Morris Woods 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 134 Saddletop Drive, Taneytown, MD 21787 William Meushaw, Jr, husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 X Other (Septembrent Evergreen Memorial 12/21/2011 Finksburg, MD 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 21. Signature of Funeral Service Licensee usti R. J Part). Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each lin of dving, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequenc) of Examiner Sequentially list conditions. trany, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) tending physician are use as the burial-Physician/Medical P.O. Box 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ģ Month Dav Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed b Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Division of Vital Records. 2 No 3 Probably 4 Unknown 1 Yes Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Jas autopsy To the Hospital or Attending Physician: The this certificate 2 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ 1 Inpatient 2 ER/Outpatient 3 IDOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending death. 1 ☐ Yes 2 ☐ No Accident Suicide Investigation within 24 hours after death

To the Funeral Director: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature a d title of certifier 29d. Date signed (Month, Day, Year) WJ 5 30. Name and address of person 31. Date filed (Month, Day, Year) 32. State

DHMH 17 Rev 7/2009

Registrar

DEC 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🔒 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Dav Physician/ Sterling Leroy Miller 2011 Medical Dec 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Carroll Hospital Center Westminster Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 D F Director 216-14-5720 89 8/9/1922 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location Director MD Carroll Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1646 St. Paul Street 21074 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 🙀 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: sowhite Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Matthews Tire Co auto parts Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ George M. Miller Evna Calp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maxine Hale Miller, wife 1646 St. Paul St., Hampstead, MD 21074 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 12/16/2011 Lineboro, MD Linebóro Cémetery 4 Donation 5 Other (Specify) Eline Funeral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M00741 934 S. Main St., Hampstead, MD 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ neymonra disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 4 Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page performed Yes 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 1 No 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 2 No 1 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier WJL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3. Time of Death

Birthplace (State or Foreign Country)

10d, Inside City Limits

Approximate Interval Between nset and Death

Month

death? 1 ☐ Yes 2 ☐ No

Day

Year

1 Yes 2 X No

MD

12:12p^M

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

DEC 1

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ P^{M} WILLIAM Α McHALE DECEMBER 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Brooke Grove Rehab and Nursing Center Sandy Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. (Month, Day, Year) Director 215-01-3469 1 🗷 M 2 🗆 F 96 Feb. 20 1915 Maryland Usual Residence of Deceden ms 23a or 28a-f show must be notified at 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director MD 01ney 1 ☐ Yes 2 🔀 No Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20832 United States 3612 Dellabrook St. items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Examiner Armed Forces? Black, White, etc. 5 þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗹 No Specify: If Yes, Give Year or Dates White "natural", 3 Widowed 4 Divorced Completed Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the U.S. Government 11 Bookbinder traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Flynn Mary Α. William Α. McHale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health al Important: If item 27 is any injury or other trau 3612 Dellabrook St., Olney, 20832 Helen M. Chittick/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 12/17/2011 Alexandria, Metropolitan Crem. 4 Donation 5 Other (Specify) 21. Signature of Fundral Service Licenses 22. Name and Address of Facility Muriel H. Barber Funeral Home Box 5038, Laytonsville, MD P.O. 20882 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Renal Failure disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Hypertension Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hypothyroid Due to (or as a consequence of): resulting in death) Last Physician/Medical spital or Attending Physician: The law requires that the death certificate be ours after death.

eral Director. After this certificate has been signed by the attending physicis filled in by the funeral director, page 2 should be detached for use as the bu Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Bladder Mass, Hypercholesterol, Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 🗌 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🗹 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

Anuradha Arun, M.D.

31. Date filed (Month, Da

Registrar's Signature

10301 Georgia Avenue, #209, Silver Spring, MD

20902

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 42932 Certificate of Death 1, Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ December 12, 2011 10:30 A M MICHAEL WINFIELD MILLER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Citizen's Care & Rehab Center If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Month, Day, Year 947 Days Hours Maryland Jan. **Director** 214-48-2621 1 🕅 M 2 □ F 64 Usual Residence of Deced 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director be notified 1 X Yes 2 No Frederick MD Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral 23a U.S.A. 21702 1900 Rosemont Avenue Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 9 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 X No Specify Specify: "natural", Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+) the High School Teacher other 1 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental F is marked o ပ Pauline Elizabeth Stitely Donald Weddle Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2510 Coach House Way 3C, Frederick, Maryland 21702 Jeff Gentry / Friend Health tem 27 item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/16/11 Frederick, Maryland Resthaven Memorial Roberto Edgre Daffiey & Son Funeral Homes, P.A. 21. Signature of Juneral Service Licens 615 East Main Street, Thurmont, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months? Month Year Day Pregnant at time of death 2 No Yes detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ No 3 Probably 4 Unknown Be Completed has Certificate: To

or Attending Physician: The law requires that the death certificate be Box 68760 P.O. Division of Vital Records, s after death. I Director: After t filled in by Hospital 24 hours

			24a. Was an autopsy performed? 1 Yes 2 No.	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes ✓ No
25. Was case referred to medical		26. Place of Death (Check of	nly one)	
examiner? 1 Yes 2 No	Hospitał: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ I	DOA Other: 4 Nursing Hom	e 5 🗌 Residence 6 l	Other (Specify)
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year) injury	28c. Injury at 28 work? 1	d. Describe how injury	occurred
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ory, office 28	Bf. Location (Street and City or Town, State)	Number or Rural Route Number,
200 Cartifier 1 Cartifying Phys	minian. To the heet of my knewledge, death accurred	at the time, date and place, and	due to the equac(s) an	d manner as stated

certifying Nurse Practitioner: To the best of my knowledge only one 29b. Signatur OX

and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 1397

30. Name and address of person who con npleted ause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination

21701 300 West Ninth Street, Frederick, Maryland Kaufmann, MD,

State Registrar

9

within 24 ho.

To the Fune

completely fi

Medical

(Check

31. Date filed (Month, Day, Year)

32. Registrar's Signature

42930

For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month December PEGGY 1:50 FAZIO MCINTYRE AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | Month, Day, Dec. 18 Frederick Memorial Hospital Frederick Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 M 2 X F Nebraska 481-20-9677 Director 86 Usual Residence of Decedent 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 275 is marked other than "natural", or items 23a or 28a-f sho ant: If item 275 is marked other than "natural", or or items be notified at ury or orber traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Frederick 1 X Yes 2 No Maryland Walkersville Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 105 Sandstone Drive, Apt. 21793 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry h and Mental Hygiene.
7 is marked other than "I traumatic event, the Mec (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Martin Fazio Mildred Peters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David McIntyre / Son 6606 Coldstream Drive New Market, Maryland 21774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 X Cremation 3 Removal from State December permit. Page Department Important: If any injury or 4 Donation 5 Other (Specify) Stauffer Crematory 17, 2011 Frederick, Maryland Sign were of F 22. Name and Address of Facility Stauffer Funeral Homes, P.A. neral Service License Frederick, Maryland 21702 1621 Opossumtown Pike 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ASPIRATION PNEUMUNIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of and burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month 4 Pregnant 9 Unknown Pregnant at time of death Other (specify) Year signed by the a Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by after death.

Director: After this certificate has been signal. 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0063498 IWADHWA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 West 7th St 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Zennie Metz December 17, 2011 6:20A. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's 5014 Lackawanna Street College Park 5. Social Security Number If Under 1 Year | If Under 24 Hrs 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 233-56-4607 Months Hours 1 □ M 2 💢 F SEBU. 3, 1938 WesttryVirginia 73 Director Yrs Usual Residence of Decedent 28a-f shov or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Prince George's College Park X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5014 Lackawanna Street 20740 United States within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Armed Forces? þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White If Yes, Give 3 Widowed 4 Divorced Completed 15. Decedent's Education 16b. Kind of Business Industry
Prince George's Co. 16a. Decedent's Usual Occupation (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Food Service Manager Board of Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H is marked ot Richard Cosner Cora Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 st of Health a item 27 is William F. Metz -husband 5014 Lackawanna Street College Park, Maryland 20740 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot cemetery, crematory or other place)

Maryland Veterans Cem. 1 X Burial 2 Cremation 3 Removal from State 12/22/2011 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Donaldad Vole Borgwardt Funeral Home, PA 21. Signature of Funeral Service Licensee 4400 Piwder Mĭll Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Cana terus Physician) disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician a hed for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? has page 2 s autonsy performed Yes 2 director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 1 No Other: မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending Matural Natural injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funeral Director; 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title ٥ 29c. License number 29d. Date signed (Month, Day, Year) 10 D45880 December 19, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hwang, M.D. 1396 Piccard Drive Rockville, Maryland 31. Date filed (Month, Day, Year) State **DEC 21 2011** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Day Physician/ 10:05 A M osephine 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Clinton Pineview Nursing Home Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** 1 □ M 2X F Months Days Hours Min 97 Yrs. Director 230-10-8936 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Prince George's Fort Washington MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20744 6801 Bock Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 ☐ Yes 2 🔀 No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 x No Specify: 3 🗆 Widowed 4 😾 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Nurse's Aide (Specify only highest grade completed) College (1-4 or 5+) City of Baltimore Elementary/Seconday (0-12) <u>Hos</u>pital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Mary Jane Williams Charlie Manuel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 159 Memorial Lane, Mt Laurel NJ 08054 Eugene Edwards/Nephew 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Baltimore, MD 11/29/2011 Arbutus Memorial 22. Name and Address of Facility Marshall-March Funeral Home 4217 9th St. NW Washington DC 20011 21. Signature of Funeral Service Licensee Janet C. Anderson per DVR 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death End Stage Physician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter concernlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami and -transit that the death certificate be executed Due to (or as a consequence of): physician ar s the burial-t resulting in death) Last Physician/Medical attending p for use as t 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) IF FEMALE 23d. Date of delivery Was decedent pregnant in the past 12 months? 1 Yes 2 No Month Year Day 1 Yes 2 9 Unknown been signed by the should be detached 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cardiomyopatho (schemic or Attending Physician: The law requires Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Lownary Artery 24a. Was an cate has t page 2 s autopsy performed? Yes 2 N Encephalopathy Anoxic 1 🗌 Yes this certificate Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: 1 Inpatient 2 I ER/Outpatient 3 I DOA within 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident 3 Suicide 4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

Medical

29a. Certifier

only one 29b. Signature and title

Date filed (Month)

determined

5

32. R gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Don Yy Seay MD &835 Sm. AVR

Hospital

Box 68760

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

10053337

Ste 203

Baltimore.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Barbara Ζ. Nelson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2**X** F Months Hours Country) 503-28-3593 Director 78 06/16/193 Minnesota Usual Residence of Decedent 28a-f show 10a. State 10b County be filed within 72 hours after death with the Maryland 10d. Inside City Limits items 23a or 28a-f sho ler must be notified at 10c. City. Town or Location Director Wicomico Maryland Salisbury 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 435 Parkwood Dr. 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. er than "natural", or i þ 1 Never Married 2 X Married 1 ☐ Yes 2 🗶 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify. 3 Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Store 12 owner/operator other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ Alys Blumberg Robert A. Zimmerman permit. Page 1 and 2 should be Department of Health and Ment Important; If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Nelson/spouse 435 Parkwood dr., Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 12/27/2011 Parsons Cemetery Salisbury, MD Ponation 5 Other (Specify) 21. Signature of Funeral Service Licens Holloway Funeral Home Professional Association -501 Snow Hill Rd., Salisbury, MD 21804 1. Enter the disease, or complications that caused the dea. . Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate nock, or heart failure. List only one cause on each Interval Between Onset and Death Immediate Cause (Final Physician/ CVD disease or condition resulting in death) Medical Due sequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis. Division of Vital Records, P.O. Box 68760 completed filled in by the funeral director, page 2 should be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably **Unknown** 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? 3 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 ☑ No Other: ျှ 1 Tes Haspiel 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence May er of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred at ohe (Month, Day, Year) Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Μ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29d. Date signed (Month, Day, Year) N 63199 23/11

Registrar

State

30. Name and

YOGESH

EASTERN SHOPE DR. SAUSBURY MD 21801

address of person who completed cause of death (Item 23a) (Type, Print)

OHPA

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 NENNA D, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death MONTGOMERY GENERAL HOSPITAL OLNEY MONTGOMERY 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number **Funeral** 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign 217-76-1722 1 M 2 X F Hours April 10,1923 England Director Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at 10d, Inside City Limits Director 1 Tes 2 No Maryland Montgomery 01ney 10e. Street and Number ь 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 2202 Eaglesham Court 20832 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. ò Completed by 1 Never Married 2 Married 2 X No ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 X Widowed 4 Divorced If Yes, Give Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ethel Heffernan William Frederick George Wales 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i 3711 Martins Dairy Circle, Olney, MD 20832 M. Gregory Nenna (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite Page 1 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. Silver Spring, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home (M01116)10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ CONGESTIVE HEART disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of Exami death certificate be executed Due to (or as a consequence of) resulting in death) Last burial Physician/Medical Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably Wunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law page performed? Yes 2 No 2 No 1 Tes Be 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 잍 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending (Month, Day, Year) To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar

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31. Date filed (Month, Day, Year,

ADEWUNMI , MD.

ADEWINNZ, MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0059418

MONTGOMERY GE 18101 PRINCE PHILLIP

12/16/2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 12/14 2011 1130am M Dorothy M. Ogden Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Regency Park Anne Arundel Gambrills 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 322-12-8282 95 **Director** 1 M 2XXF 8/1/1916 ILms 23a or 28a-f show must be notified at Ioa. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XXNo MD Anne Arundel 0denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 0denton USA 558 Williamsburg Lane death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes ※XXNo
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes No Specify: White Specify: "natural", Completed 3XXWidowed 4 □ Divorced Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Sylvia Frye Harry Riggens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Odenton, MD 21113 558 Williamsburg Lane Rebecca Petersen Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Hurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/27/2011 East Moline, IL Greenview Memorial 21. Signature of Junyal Service Licer 22. Name and Address of Facility Hardesty Funeral Home, P.A. Val Annapolis, MD 21401 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause nterval Betwe et and D on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Par Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of,: J physician and as the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Left Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ___ in the past 12 mon Day Pregnant at time of death 1 Yes 2 g 2 No the 9 Unknown Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy nerform certificate Yes To the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 Yes Other: _2 🗐 Nyd မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred After t Certificate: 1 Natural 5 Pending 1 Yes 2 No neral Director: A filled in by the fu after death ☐ Accident ☐ Suicide Investigation 6
Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 00

Registrar

DHMH 17 Rev 06-2011

State

pleted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 Palombo 13 Louis December ам 6:58 Medical 4a. Facility Name (if not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav) **Funeral** Country) Italy Months Hours Min Aug. 7, 1932 1 ₺ M 2 🗆 F 184-24-6358 79 Yrs **Director** Usual Residence of Deceden ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 23700 Eli Lane 20882 USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑ Yes 2 ☑ No
If Yes, Give Korean
Year or Dates. Conflict 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 X Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Megonee. Elementary/Seconday (0-12) College (1-4 or 5+) Robotic Engineer Government Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname, ပ Joseph Palombo Julia Leo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Camille Palombo/Wife 23700 Eli Lane, Gaithersburg, MD 20882 Date 23, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dec. 2<u>011</u> 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Gate of Heaven Cemetery Silver Spring, MD 4 Donation 5 Other (Specify) Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd. W., silver Spring, 23a. Part 1. Enter the disease, or complications that cause 112 death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARCINOMA Physician/ LUNG disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Litter onderlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Physician: The law requires that the dea h cer ficate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the a lending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month 1 Yes 2 L b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy Yes 2 X No 1 🗌 Yes 2 🗌 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Hospita 유 1 Tes 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify Director: After this OMBO,L Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending 1 Natural 2 Accident injury work?
1 Yes 2 No 5 Pending Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 6+1 DEC. 19, 2011 D23308 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

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31. Date filed (Month, Day, Year)

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ROCKUEDGE DA. BETTESOA MO 20317

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ [□]19,2011 Maria Concepcion Ramirez December 12:10 p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Hospice-Casey House Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours 577-90-1383 Director 1 M 2 X F 67 Nov. 29, 1944 Nicaragua Usual Residence of Dec 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland Funeral Director must be notified 1 ☐ Yes 2 🛱 No VA Fairfax Alexandria 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a 404 N. Armistead Street 22312 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S Examiner Armed Force Black, White, etc. or þ 1 X Never Married 2 Married 2 🔀 No 1 Yes Specify. White Baltimore, Maryland 21215-0036 within 72 hours after 1 □Xyes 2 □ No Specify: Nicaraguan "natural", Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 0 Housekeeper Domestic Cleaning . Page 1 and 2 should be filed v ment of Health and Mental Hyg tant: If item 27 is marked othe Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Jose Mercedes Ramirez Angelica Rodriguez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carlos A. Abarca/Son 404 N. Armistead Street, Alexandria, VA 22312 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 A Burial 2 Cremation 3 Removal from State ö Department of Important: If any injury or once, Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD Signature of Funeral Service Licenses 22. Name and Address of Facility
Francis J. Collins
500 Unviersity Blvd. Funeral Home Inc. W, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Cancer Endometrial Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): and and Cause (Disease or mijury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician the for use as the buria Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 Fetal death in the past 12 months? Month Year Pregnant at time of death Day 1 ☐ Yes ∠¬= g ☐ Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 performed? Yes 2 N 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospice
6 Other (Specify examiner? Hospital: 2X No Other: 1 Yes မ ER/Outpatient 3 DOA 1 Inpatient 2 I 4 Nursing Home 5 Residence Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: Aignorpletely filled in by the fu

2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 1 🗓 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 30. Name and address of berson who complete G. Coleman, MD

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

D37142 December 19, 2011

cause death (Item 23a) (Type, Print)

1355 Piccard Drive, Rockville, MD 20850

31. Date filed (Month, Day, Year) DEC 2 2 2011

Registrar

Medical

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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	•	For State Registrar		01	iate oi	iviai yiai		ertificat			and n	nontan		No. 2 ()	42941
Physicia	n/	1. Decedent's Name	e (First, Middle	, Last)					-			2. Date o	f Death			3. Time of Death
Medic	al	John W. 4a. Facility Name (if			and numb	no ri		1 41- 034-	T	Lasation	of Dooth	Dece	mber	16,		12:00p ^M
Examin	er	10997 Ho		_		oer)		4b. City, Town, or Location of Death Frederick				4c. County of Death Frederick			ick	
Funeral		5. Social Security Nu		6. Sex		7. Age (In yrs.	last birthday	If Unde	r 1 Year Days		r 24 Hrs.	8. Date o	Birth , Day, Ye:			place (State or Foreign
Director		216-60-8 Usual Residence of		1 X M	2 🗆 F	60	Yrs.					June			!	ryland
f show	tor	10a. State	10b. County			10c. C	ity, Town or L	ocation							1	0d. Inside City Limits
e Mary r 28a-i notifie	Direc	Maryland 10e. Street and Num		dericl	c	Fre	deric		0.1.					0111 6		1 Yes 2X No
vith th	Funeral Director			o Desir				101. 21	o Code	0.1				. Citizen of		
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after c	Completed by	1 Never Marri		ried 1	☐ Yes Yes, Give	2 🔀 No		1 ☐ Yes 2 🛛 No Specify:				Thours, otony		Specify	ck, White,	
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ed with Hygier other t	a)	12 17. Father's Name (F	First, Middle, L	ast)				Arborist 18. Mother's Name (First, Middle,					Idle Maid		Serv	ice
l be file fental rked c		John W. Rippeon Sr. Mary L. Esworthy								,0,						
should and N is ma		19a. Informant's Na		1 1 21 2	int)		19b. Ma	ling Addres	s (Street a	and Numb	er or Rura	al Route Nu	mber, Cit	y or Town,	State, Zip 0	Code)
and 2 Health em 27 ther tr		Sally Ri		Wife		206	109!			oe D			Т	ck, Man		d 21701
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 🔀 Burial 2 [4 🗆 Donation	☐ Cremation		val from S	State	cemetery, cr	ematory or o	other place			21/201 201/201	l 1		•	aryland.
permit. F Departm Importal any injul once.		21. Signature of un														
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Physician/ Medical		disease or condition resulting in death)		a	Due to (o	r as a consec		20/10		77106	7 100			, ,,	-	30400
Examiner	e.	Sequentially list our	nditions,	b —												
ed nsit	Examiner	Segmentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury														
be executed sician and burial-transit		that initiated events resulting in death) L	3	c. —	Due to (o	r as a consec	quence of):								$\neg \uparrow$	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans.	dical			d											_	
requires that the death certificate b been signed by the attending physi should be detached for use as the t	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent	pregnant			ome of <u>pr</u> egn								23d Da	ate of deliv	erv.
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at the d	Phy	9 Unknown Part II. Other signifi	icant conditio				sulting in the	underlying	cause giv	en in Par	t I.	230 [oid tobac	CO USE CON	tribute to th	ne cause of death?
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The la ate ha page	E											F	utopsy performed Yes 2		death?	
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g Physer this	e: To	27. Manner of Death	1		Ba. Date o	npatient 2 [28b. Time		OA 28c. Injury	4 <u>N</u> ∙at		ome 5. 28d. Descr)
ecth. or Aft	ificat	1. Natural 2 ☐ Accident 3 ☐ Suicide	5 ☐ Pendin Investiç 6 ☐ Could	gation		ı, Day, Year)	injury	M		Yes 2	□No					
or Att	Certificate:	4 Homicide	determ			of Injury - At h g, etc. <i>(Specil</i>		treet, factor	y, office				on (Stree Town, S		oer or Rural	Route Number,
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director After this certificate has completely filled in by the funeral director, page 2	Medical		Certifying													
the Ho hin 24 the Fu	Med	only one) 3	Certifying					e, death occ	curred at th	ne time, d			to the ca	ause(s) and	manner as	
o N with		29b. Signature and t	title of certifier	1/				29	c. License	number	5152	/	29d.	Date signe	ed (Month, i	Day, Year)
,		30. Name and addre	ess of person v	who comple	ted cause		n 23a) (Type	Print) Johns	N					.4	. 7 .	7. /
3		J. Z.	Kran	٦ /	10	10 1		Johns	ind L)2,4¢	- 1	redir	1cle,	MR	1 41,	19/
Stat Registra		31. Date filed (Month)EC 2 1	2011	100	gistrar's Signa	A. A.	barke	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Marylant		ificate of De			Reg. No.		
	Physicia	n/	1. Decedent's Name (First, Middle, Last)	11.				2. Date of Dea	th	3. Time of Death	
	Medic	al	Alice Palmer R 4a. Facility Name (if not institution, give str	obbins		4b. City, Town, or Lo	postion of Dooth	Decembe	er 20 201 4c. County of Dea		
	Examin	er	2116 Horns Point				bridge			hester	
	Funeral Director		218-16-86/6	M 2 🕅 F 7. Age (In yrs. las	st birthday) Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birt JULY T		thplace (State or Foreign unitry Land	
	and show dat		Usual Residence of Decedent 10a. State 10b. County		, Town or Loca		1			10d. Inside City Limits	
_	Maryl 28a-f notified	irec	MD Dorche	ester			nbridge			1 ☐ Yes 2 🛣 No	
3	h with the ns 23a or nust be r	Funeral Director	10e. Street and Number 2116 Horns Point				21613		10g. Citizen of What CoUSA	ountry?	
J 9EOC	ırs after deat ural", or iten il Examiner r	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		as Decedent of Hisp Yes, specify Cuban, Yes 2 No	14. Race - American Indian, Black, White, etc. Specify: white				
1215-(hin 72 hou ne. than "nat ie Medica	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Seconday (0-12)		(Give kind of work done during most of working					. Kind of Business Industry own home	
1d 2	iled wit I Hygie other ent, th	Be	17. Father's Name (First, Middle, Last)						Maiden Surname)	inc	
ylar	ild be f Menta narked iatic ev	욘	Emmett R. Palmer				Edith	Harris			
, Mar	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type Edwina Sipler	daughter	2116	Horns Poi				1613	
Baltimore, Maryland 21215-0036		1 Burial 2 □ Cremation 3 □ Removal from State Antioch Churchyard 12/23/11								Cambridge, MD	
Balt	permit Depart Import any inj		21. Signature of Funeral Service Licensee	>		Name and Address OO Locust			neral Home e, MD 2161		
- 1	Physician/	- 74	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	cause on each line.	. Do not enter	the mode of dying,		or respiratory arr		Approximate Interval Between Onset and Death	
	Medical Examiner		resulting in death)	Due to (or as a conseque		7400					
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68760	rificate ing phy		IF FEMALE:	15							
Box	Attending Physician: The law requires that the delath certificate be executed ir death. exter this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transi	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregnar 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year	
P.O.	requires that the de been signed by the should be detached	by Ph	Part II. Other significant conditions cont	ributing to death but not resu	ulting in the un	derlying cause giver	n in Part I.	23e. Did to	bbacco use contribute t	o the cause of death?	
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Secol	The law re ate has be bage 2 sh	Completed					-	24a. Was autor perfo 1 \(\sum \) Yes	psy prior to rmed? death?	utopsy findings available completion of cause of	
ta	cian; ertifica ector, p	Be	25. Was case referred to medical examiner?	spital:		26. Plac	e of Death (Chec.				
of Vi	Physi er this c eral dir	e: 10	1 ☐ Yes 2 № No 27. Manner of Death	1 Inpatient 2 I	28b. Time of	3 ☐ DOA 28c. Injury a			ience 6 Other (Spe	cify)	
on o	ending sath. or: Afte he fune	ficat	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	M 1 □ Ye	es 2 🗆 No				
Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.	al Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Hornicide determined	28e. Place of Injury - At hor building, etc. (Specify)		et, factory, office		28f. Location (S City or Tow	itreet and Number or Ri In, State)	ural Route Number,	
	To the Hospital or within 24 hours afte To the Funeral Director Completed filled in Inc.	Medical	(Check 2 Medical Examine	ian: To the best of my knowle r: On the basis of examination Practioner: To the best of my	and/or investig	gation, in my opinion,	death occurred a	t the time, date a	nd place, and due to the	cause(s) and manner stated.	
	To the within to the congression of the congression		29b. Signature and title of certifier	MD	-	29c. License n			29d. Date signed (Mon.	th, Day, Year)	
	•		30. Name and address of person who con				CAMBRID	C E	MARYLAND	21613.	
	Stat	e	JEEVAN ERRABOLO 31. Date filed (Month Day Year) 32 2 20		-	a Mad	Chirloki D	W.C.	1.14~1-147		
	Registra	ar	UEU 22 20	11 Jeneura	12. 14	DATA COLOR					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day **Physician** C. Wilbur Robinson 19, 2011 2:45a Dec. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Long View Nursing Home Manchester Carroll If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1√2 M 2 □ F 219-14-1000 89 Director Feb 15, 1922 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show 1 ☐ Yes 2 ☐ No 7 is marked other than "natural", or items 23a or 28a-f sl traumatic event, the Medical Examiner must be notified Hampstead Director MD Carroll 10g, Citizen of What Country? 10e Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natura". any injury or other traumatic events. 229 Houcksville Road 21074 IISA Funeral 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 Tyes 2 No WWII If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No white Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) self employed plumber plumbing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Reuben Robinson ပ္ Nina Anderson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 229 Houcksville Road, Hampstead, MD 21074 Laura Robinson, wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Carroll Cremation 12/20/2011 Hampstead, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eline Funeral Home M00741 934 S. Main Street, Hampstead, MD 21074 Denne 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an the Hospital or Attending Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes | 2 | No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation 1 Natural 1 🔲 Yes death. nours after death.

neral Director: # 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1🗖 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only

To the Hospital of within 24 hours af To the Funeral D completely 8+1 VA

> State Registrar

29b. Signature and title of certif

DHMH 17 Rev 1/2001

and manner stated.

mD strar's Signature

cause of geath (Item 23a) (Type, Print)

ele Kd. Westminster MD 2457

29c. License number

29d, Date signed (Month, Day, Year)

		•	For State of Maryland State of Maryland Registrar		artment of F tificate of L		d Mental Hy	glene Reg. No.		
	Physicia	ın/	Decedent's Name (First, Middle, Last) Linda Ann Rill	•			2. Date of De	eath Dav	Year	3. Time of Death
	Medic Examir	al	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of D	Decemb	<u>er 18</u>	2011 County of Death	2:22p. M
ne!	Exami	ei	3501 Emory Road North		Uppe		COULT	40.0	Carroll	
	Funeral	Г	5. Social Security Number 6. Sex 7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Bi	rth av, Year)		place (State or Foreign
	Director		220–48–2367 1 □ M 2 □ XF 64 Usual Residence of Decedent	Yrs.			1/12/		MD	,,
	land show	후	10a. State 10b. County 10c. City	, Town or Loc					1	0d. Inside City Limits
	Mary 28a-f otifie	irec	MD Carroll	Uppe						1 🗆 Yes 2 🔀 No
	n with the is 23a or nust be r	Funeral Director	10e. Street and Number 3501 Emory Road North		10f. Zip Code 21155			10g. Citiz US.	en of What Coun A	try?
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes ★ No If Yes, Give Year or Dates.	n U.S. 13. Was Decedent of Hispanic Origin? (Specify Yelf Yes, specify Cuban, Mexican, Puerto Rican, 1 1 ☐ Yes 2 ▼ No Specify:			? (Specify Yes or No- uerto Rican, etc.)	es or No- etc.) 14. Race - Am Black, Wh Specify: Whi		etc.
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pue	e filed that Hydel ed oth event	To Be	17. Father's Name (First, Middle, Last)			_	Name (First, Middle	, Maiden Su	ırname)	
ıryla	ould by the part of the part o	_	Guy A. Waddell 19a. Informant's Name/Relationship (Type, Print)	10h Mailin	a Address (Street a		Rural Route Number	or City or T	our Ctata 7in C	
, Ma	nd 2 sh ealth ar m 27 is ier trau		Dennis L. Rill, husband	1			th, Upper		,	
Baltimore,	Page 1 annent of Haurt of Haurt If itel		1 X Burial 2 Cremation 3 Removal from State	emetery, crem	sition (Name of natory or other plac Cemetery		Date /22/2011	l	ation - City or To stead, 1	
Balti	permit. Departr Importa any inju	93	21. Signature of Funeral Service Ligensee M00741	22.	. Name and Addres	ss of Facility	Eline Fu			74
			23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	. Do not ente	r the mode of dying	g, such as car	diac or respiratory a		rib zio	Approximate Interval Between
. 10	Medical	i ii			atri	Canc	er			Onset and Death
فمجهد	Examiner		Due to (or as a conseque	ance of):						
	- =	Examiner	Sequentially list conditions, b. but to (or as a consequence sequence).	souther to the						
	ecuted and I-trans	Exan	Cause (Disease or injury that initiated events resulting in death) Last	ence of:						
0	icate be executed physician and is the burial-transit	edical I	d							
8760	tificate ng phy as the		IF FEMALE:							
89 xc	requires that the death certifi been signed by the attending should be detached for use a	Physician/N	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant 1 ☐ Live Birth 2 ☐ Fetal	death 3	Ectopic pregnanc	у		23	3d. Date of delive	ery Dav Year
Box	he dea y the a iched t	nysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of de 9 ☐ Unknown 9 ☐ Unknown	∌ath 5 □	Other (specify)				WOILIT	Day real
	s that t gned by	by PI	Part II. Other significant conditions contributing to death but not resu	ilting in the ur	nderlying cause giv	en in Part I.	23e. Did t	obacco use	contribute to the	e cause of death?
Ġ Š	requires been sign should be						_ 1 🗆	Yes 2	No 3 ☐ Prob	pably 4 Unknown
Secol	law has je 2	Completed						psy ormed?	prior to cor death?	osy findings available impletion of cause of
<u></u>	sician: The certificate rector, pag	Be C	25. Was case referred to medical examiner?		26 . Pla	ace of Death (C	1 \(\sum \) Yes Check only one)	2AC NO	1 🗌 Yes	2 LTN0
₹	Physic this ce al dire	은	1 Yes 2 No Hospital: 1 Inpatient 2 E			4 ☐ Nursir	ng Home 5 Resi	dence 6	Other (Specify)	
o uc	nding F ath. r: After ie funer	icate	27. Manner of Death 1	28b. Time of injury	28c. Injury work' M 1 🗆		28d. Describe	how injury o	occurred	
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Il Certificate:	3 Suicide 6 Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	28e. Place of Injury - At home, farm, street, factory, office					Number or Rural	Route Number,
	ne Hospi n 24 hou ne Funer oletely fii	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowle a Medical Examiner: On the basis of examination only one) 3 Certifying Nurse Practitioner: To the best of my knowle	and/or investi-	gation, in my opinio	n, death occur	red at the time, date	and place, a	nd due to the cau	se(s) and manner stated.
			29b. Signature and title of certifier		29c. License	number		29d Date	signed (Month I	lav Year)
	WIL		groundy was	<u>~</u>		3740	12 113	ι	1111/2	.011
					7, BAST	MAIN	IST. W	ESTA	UNITED	2 40215,
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signatu	re d. s	backer					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Maryla			nt of H te of L		ind Me		giene Reg. No	201		42945
	Physic /Medi		1. Decedent's Name (First, Middle, Last Clyde Richa	rd Reynolds						2. Date of Dea 12	17	y 201	i	3. Time of Death 11:00 A.M
	Exami	ner	4a. Facility Name (If not institution, give 18920 Sandy Hook	Road		Kn	oxvil					a. County of Di Nashing		
	Funeral Director		5. Social Security Number 6. Se 215-42-3730 10	*	rs. last birthday) 68 Yrs.	If Unde Months	or 1 Year Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Day 5-2-19	h y, Year, 143	9. E	Country	ce (State or Foreign () land
	Maryland e-f show	ctor	10a. State 10b. County Washing		City, Town or Lo								100	t. Inside City Limits 1 ☐ Yes XXNo
	th with th	Funeral Director	10e. Street and Number 18920 Sandy Hook	Road		10f. Z	ip Code	217	58		10g. Ci	tizen of What USA	Country	/?
9036	be filed within 72 hours after deeth with the Maryland tal Hygiene. Ved other then "netural", or itema 23a or 28a-f ahow evant, the Modical Examinar must be notified at	by	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 (X)Yes 2 □ No If Yes, Give Year or Dates: 19	If Yes, sp	Vas Decedent of Hispanic Origin? (Specify Yes or Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes XX No Specify:			offy Yes or No- lican, etc.)	14. Race - American In Black, White, etc. Specify: White		c.		
Maryland 21215-0036	filed within 72 h Hygiene. other then "netu int, the Medica	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12	cation e completed) College (1-4or 5+)	life.	kind of w	ork done d use retired)	uring most			Lo	dging of Busine	ss/indu	stry
yland	should be filed with and Mental Hygiene i marked other the umatic evant, the	To Be	17. Father's Name (First, Middle, Last) Lester Reynolds					Mai	rian	Green				
, Mar	Pages 1 and 2 and 1 and 1 dent of Health are sut; If item 27 is ury or other traus		19a. Informant's Name/Relationship (T) Mary Reynolds - W	ife	1892	0 Sar	ndy H			Route Numbe (noxvil			1758	
Baltimore,			20a. Method of Disposition 1 Burial 2 Coremation 3 F 4 Donation 5 Other (Specify)	Removal from State	Place of Dispo cemetery, crei agersto	matory or	other place		Da 12-19			ocation - City erstow		
Ball	permit. Departr Importe any inju		21. Signature of Funeral Service Licens Round L. Soun	me Mo	0970 A	ackle arper	s-Sp	s of Facility encer rry,	w\$ No	25425 F		ral Ho	me	
d.	Physician /Medical Examiner		23a. Part1. Enter the disease, of complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cons	CARO			such as co	_		rest,		li C	pproximate nterval Between onset and Death
8760,	icate be executed physicien and s the burial transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons		eli							ı	moulh
O. Box 6	the death certif y the attending iched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	⊒Ectopic pregnancy] Other (specify)					23d. Date of o Month	delivery Da	ay Year			
rds, P	9 9	þ	Part II. Other significant conditions con	ntributing to death but not r	esulting in the u	nderlying	cause give	n in Part I.			bacco es 2			cause of death?
	The lar	Completed	2						-	24a. Was a autop perfor 1 Yes	SV	prior t death	o comp	y lindings available letion of cause of
<u> </u>	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	lospital:			Othe			Check only or				
o	Physic ruthis ral di	. To	1 Yes 2 NNo 27. Manner of Death	1 Inpatient 2	☐ ER/Outpatien 28b. Time of		04	4 📖 (Vuit)		e 5XXResid			pecify)	
sion	Attending or death. actor: After by the funer	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year)	Injury	М		es 2 □ N	0					
Ω	urs after or a street or all Dirac		4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	cify)					I. Location (S City or Tow	n, State	9)		
	To the Hospital or Attanding Physician: within 24 hours after death To the Funeral Director: After this certific completely filled in by the funeral director,	ledical	one) 2 Medical Exami	sician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, death nation and/or in	occurred vestigation	at the time n, in my opi	e, date and inion, death	place, an	d due to the o	ause(s date and) and manner d place, and d	as state lue to th	ed. ne cause(s)
	To To con	×	29b. Signature and title of certifier A - Z - V	HEGHZI			c. License	+4	16	4		2 - I		
	6		30. Name and a cress of person who co	1, aus, 46	BT	Print)	ive	Fre	de	ech.	MU	121	70	2
	Sta Registr		31. Date filed (Month, Day, Year)	32. Finistrar's Sig	nature	m. Ha	B							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death DECEMBER 22, 2011 Physician/ 7:40 \mathbf{P} M JOHN FRANCIS SCULLY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** QUEEN ANNE'S CORSICA HILLS NURSING HOME CENTREVILLE If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth **Funeral** 6. Sex Age (In yrs. last birthday) Days 1 **X** M 2 \square F Hours Min MARCH DEX 8 NEW YORK 72 1939 Director 578-50-1922 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MARYLAND QUEEN ANNE'S CENTREVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 149 SONATA WAY 21617 USA within 72 hours after death items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No
If Yes, Give 105 Black, White, etc. "natural", or þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 WHITE 1 Tes 2 X No Specify: Yes, Give 1959-1960 Specify: 3 🗆 Widowed 4 🗆 Divorced Completed event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 CONSTRUCTION SHEET METAL MECHANIC is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file and Mental ၉ JOHN VINCENT SCULLY CATHERINE MULANEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 149 SONATA WAY, CENTREVILLE, MARYLAND 21617 JUDITH S. SCULLY/ WIFE other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State DEC. 24 Department of H Important: If ite any injury or ott once. 1 Burial 2 Cremation 3 Removal from State CHESAPEAREY CREMATION 4 ☐ Donation 5 ☐ Other (Specify) 2011 CENTER STEVENSVILLE, MARYLAND 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MARYLAND 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ mer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) that the death certificate be executed burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 2 **3**No ned by the a 1 Yes 2 Q Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page death? 1 Yes 2 No Yes 2 No Hospital or Attending Physician: Division of Vital Be 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Accident
2 Accident
3 Suicide
4 Homicide (Month, Day, Year) 5 Pending injury 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar

+19.00

29b. Signature

30. Name and address

200 31. Date filed (Month, Day, Year)

2

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

2/07

29c. License number

DiDant Prime Charles Me) 2/6/9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Mary Helen Slater 2011 December 11:35 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours 490-34-0278 **Director** 1 🗆 M 2 🕱 F 80 July 30, 1931 Missouri Usual Residence of Deceder 28a-f show with the Maryland notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Damascus ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 26521 Howard Chapel Drive 20750 United States within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2XX Married ģ Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White Completed 3 Widowed 4 Divorced er than "natur , the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, it Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ollis Ray Cheek Mary Blanche Burris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Billy Slater / Husband 26521 Howard Chapel Dr., Damascus, MD 20750 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XX Cremation Dec 3 Removal from State Resthaven Crematory 4 Donation 5 Other (Specify) 2011 Frederick, Maryland of uneral Se Signature Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, 23a. Part 1. Enter the dise shock, or heart failing or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death List only one cause on each line Immediate Cause (Final Ph_sician/ Complications of Pulmonary Fibrosis dise or condition resulting in death Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence or) To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 X No Day Pregnant at time of death been signed by the a should be detached t 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director: After this certificate Yes 2 X No 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospice House 1 ☐ Yes 2 🔀 No Other: 은 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 🛛 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending injury ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, D0060634 December 18, 2011

Registrar
DHMH 17 Rev 06-2011

13

State

6001 Muncaster Mill Rd., Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Bindu Joseph, M.D.

DEC

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State of Registrar	Maryland			f Health a	nd Menta	l Hygiei	2011	42948	
	Dharisi		Decedent's Name (First, Middle, Last)					2. Date	of Death	Day Year	3. Time of Death	
	Physici /Media		Anna Elizabeth Smac	k				Dec			1 6:40 AM	
7	Examir	er	4a. Facility Name (If not institution, give street and num	nber)		4b. City, Tow	m, or Location of	f Death		4c. County of Dea		
			10742 Flower Street 5. Social Security Number 6. Sex	7. Age (In yrs. last	hidhday)	Berlin		4 Hrs. 8 Date	of Birth	Worcester		
В	Funeral Director		213-05-0865 1□M 2⊠F	96	Yrs.		ays Hours	Min. (Mor	of Birth oth, Day, Ye 08/191	ar) 5 M:	rthplace (State or Foreign country) aryland	
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Lo	cation					10d. Inside City Limits	
	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hyglene. Depertment of Health and Mental Hyglene important: If Item 27 is marked other than "neturel", or Items 23s or 28s-f show stry Injury or other traumatic event, I'm Medical Examinal must be notified at once.	ţō	Maryland Worcester	Berl							1 ☐ Yes 2 ★No	
	h the	by Funeral Director	10e. Street and Number	DOLL		10f. Zip Coo	de		10g.	Citizen of What C	country?	
	23a c	alD	10742 Flower Street			2181	1			USA		
	r dee	Iner		dent Ever in U.S.	13. \	Was Decedent f Yes, specify (of Hispanic Orig Cuban, Mexican,	in? (Specify Yes Puerto Rican, e	or No-			
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9	hour	ed b	3 Widowed 4 Divorced Year or Da		6a Decec	dent's Usual Oc	cupation		16h	. Kind of Business	Black	
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yla	Men Marke Maric	ဥ	George Woodly Smack, S					san Jane				
Maryland	nd 2 shall hand lith and 27 ie m		19a. Informant's Name/Relationship (Type, Print)							ty or Town, State,		
	Heall Heall tem 2		Kendra Smack 20a. Method of Disposition			FIOWEI sition (Name of natory or other		- Berni		Maryland 21811 20c. Location - City or Town, State		
Baltimore,	Pages nent of unt: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from 5 4 ☐ Donation 5 ☐ Other (Specify)	olale			1	19/97/96				
alti	Depermit. I Depertm Importar eny Injur		21. Signature of Funeral Service Licensee	St. F	22	. Name and Ad	dress of Facility	12/2//20 1213 Je	rsev F	erlin, Mar Road - Sa	alisbury, MD	
m	Depermine Depe	1. 3	Patricia a. A.	Mey)			AL CHA	_		21801	
			23a. Part1. Enter the disease, or complications that conshock, or heart failure. List only one cause on each	used the death. D	o not ente	er the mode of	dying, such as c	ardiac or respira	itory arrest,		Approximate Interval Between	
a li	Physician		Immediate Cause (Final disease or condition	orde	+All	0,40	Certif	aelu	re		Onset and Death	
	/Medical Examiner		resulting in death) Due to (or as a consequence	ce of):	2	0 = 1	1500	066)		
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P.O.	the d	ysi	1 ☐ Yes 2 ☐ Yoo 4 ☐ Pregna 9 ☐ Unknown. 9 ☐ Unkno			TOTAL (Specify						
	res thet signed to be deta	by Physician/Med	Part It. Other significant conditions contributing to de	ath but not resulting	g in the ur	nderlying cause	given in Part I.	23e	. Did tobacc	o use contribute t	to the cause of death?	
Records,	The law requires that the death certifica tie hes been signed by the attending ph bage 2 should be detached for use as th								1 🗆 Yes	2 ∆ €0 3 □ P	robably 4 \understand Unknown	
ecc	e law re hes be je 2 sho	Completed						24a	. Was an autopsy	24b. Were a	utopsy findings available completion of cause of	
_		Con						10	performed Yes 2	? death?	s 2 No	
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner? 1				*:	of Death Check	only one			
ō	ਜ਼ ≑ ਜ਼	2	1 ☐ Yes 2 ☑ No ☐ 1 ☐ tr 27. Manper of D ath 28a. Date of	patient 2 ER/	Outpatien b. Time of	I JU DOA				6 Other (Speniury occurred	ecify)	
Division of	Attending I ar death. ector: After by the funer	tior	Natural 5 □ Pending (Month ☐ Accident investigation	i, Day Year)	Injury	1	njury at Work? 1 ☐ Yes 2 ☐ N		ionoc now ii	ijary oodariog		
		Certification;	3 Suicide 6 Could not be determined 28e. Place	of Injury - At home, g, etc. (Specify)	farm, stre	eet, factory, offi	ice		ation (Street or Town, St		Rural Route Number,	
٥	Ital or A		Sunda	g, etc. (Specify)				City	or rown, st	ate)		
	Hosp 24 hou Fune tely fil	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the back only and many a	sis of examination	dge, death and/or inv	occurred at the	e time, date and ny opinion, death	place, and due on occurred at the	to the cause	e(s) and manner a and place, and du	is stated. le to the cause(s)	
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in I	Med	29b. Signature and tiple of Applier	er stated.			ense number			Date signed (Mon		
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	210		30. Name and address of person who completed cause	of death (ttem 23)	a) (Type, I	Print)	wo.	/ L L L	4 4	ecen.	111	
	5		Soll & Douters	K MD	15	5 N. 1	Wiltic	LNS 3	* E	20/00/1	ille DE 199	
	Sta		31. Date filed (Month Pan. Y 2/17 2011 32. 14	gretrar's Signature	1 6	and				1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Sarah Ethel Smith 2011 December Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Carroll County Carroll Hospital Center Westminster 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours (Month, Day, Yea 1 □ M 2 💢 F 215-42-6350 Marvland Director 67 1944 Usual Residence of Decedent 28a-f show 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Carroll County Hampstead Maryland| 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral United States items 23a 1368 Lare Street 21074 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ò δ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: white 'natural", Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) sewing factory presser 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F rermit. Page 1 and 2 should be fill epartment of Health and Mental Important: If item 27 is marked only injury or other traumatic every ည Cherie Gill Coral Eldred Magers 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gettysburg, PA 17325 Sally Harmon / daughter 95 South Avenue 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Fairmount Cemetery Libertytown, Maryland 4 Donation 5 Other (Specify) 2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eline Funeral Home creet Hampstead, Maryland 21074 M01072 934 South Main Street ur 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final Onset and Death Physician/ Loroma disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Examir attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of resulting in death) Last Physician/Medical IF FEMALE: signed by the attendir 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown g Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? After this certificate 2 🗌 No Yes 2 N 1 Yes To the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director: After this certifica completed filled in by the funeral director, to 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1 Natural Accident 1 Yes 2 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

WJL 5

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

State Registrar 29b. Signature and title of certification

31. Date filed (Month, Day, Year)

NILAR

MD

Washington

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NILAR U 912 Washington K

D0065246

westmenster

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Z Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12:30A Physician/ December Day 7, 204al Lyda L. Schubert Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Min. 1 M 2 XF Hours 09/28/1922 220-16-4401 89 Pulaski, VA Director Usual Residence of Decedent 28a-f show should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a مت 29a عد 29a مت 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Anne Arundel Annapolis MD10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21401 525 Ridgely Ave 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces? 1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Own Home Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ Hobert O'Dell Lora Vienna Spencer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 525 Ridgely Ave Annapolis,MD 21401 Edward E. Schubert Spouse Baltimore, 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Glen Burnie, MD 12/19/2011 Atlantic Crematory 12 Ridgely ve Annapolis, m 21401 Signature of Fun Name and Address of Facility Hardesty Funeral Home P.A. an 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Solvation disease or condition resulting in death) Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed -tran and Due to (or as a consequence of) resulting in death) Last burial physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown þ signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page performed? Yes 2 2 No this certificate 2 🗌 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗷 No Hospital Other: 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Matural 5 Pending of Funeral Director; After death.

Funeral Director; After deted filled in by the fun Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1'🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) d title of certifie 29b. Signat MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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Annapolis MID

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 295 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 1 Month. 1:15PM ean Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Manufand Medical University Itimore Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 9, **Funeral** Birthplace (State or Foreign Country) Days Min. 216-42-7214 **Director** 1 □ M 2 🎛 F 69 Maryland Usual Residence of Deced show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Annapolis 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1216 Destiny Circle 21409 USA items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. or þ 1 Never Married 2 X Married Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White "natural", Completed 3 🗌 Widowed 4 🗌 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker **Home** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Chester Joseph Wisniewski Genevieve Martha Lewanowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry South/Husband 1216 Destiny Circle Annapolis, MD 21409 Date 23, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 20**1**1 5 Other (Specify) Glen Haven Mem. Park Glen Burnie, MD 4 Donation Signature of Functal Service Lioths Barranco & Sons, Severna Park Funeral Home 495 Ritchie Hwy. Severna Park, MD 21146 art 1. En er the disease, or comp shock, or leart failure. List only cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. Approximate Interval Between Immediate C se (Final Onset and Death Physician/ iver failure disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the attending physician and hed for use as the burial-transit requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No completely filled in by the funeral director, page 2 should be detached for Day Year Pregnant at time of death 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has actopsy performed? 2 No 1 Yes To the Hospital or Attending Physician: ⁻] within 24 hours after death. To the Funeral Director: After this certifice Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 **Y** No ဂ္ 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending Accident 1 L Yes 2 🗌 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 1962727420 MD 12/19/11 30. Name and addre on who completed cause of death (Item 23a) (Type, Print) Greene St, Baltimore, MD 21201 State

Registrar

DEC 2 1 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 24a per med cert G923 I/II/II dk. State of Maryland / Department of Health and Mental Hygiene For State Registrar 42952 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Year uther 2:58 DM tranklin 23 recember 3011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 704 Concord Drive Perryville Ceci1 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1 🛣 M 2 🗆 F Months Days Min Hours Director 215-34-5454 76 Yrs Maryland Dec 1935 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or one once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Maryland Cecil Perryville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 704 Concord Drive 21903 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status vas Decedent Ever in U.S. Armed Forces? $1 \text{ \mathbb{Z} Yes} = 2 \square \text{ No}$ If Yes, Give Year or Dates. 1958-6014. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🔀 No Specify: 3 🕅 Widowed 4 🗆 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Pirelli Cable life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Elkton, Maryland Cable Operator Twelve Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Luther S. Schoff Lehlia Ella Underwood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delcina S. Creswell (daughter) 1446 Clayton Street, Perryville, Maryland 21903 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ₺ Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place, Port Deposit, 4 ☐ Donation 5 ☐ Other (Specify) 12/29/11 Cemetery Maryland Signature of Funeral Service Lice 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Maryland 21903-0766 Perryville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 2 No 2 No 1 Tes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? in 24 hours after oeaun. he Funeral Director: After this of noleted filled in by the funeral dire Other: 2 No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check within 2 3 🗆 Certifying Nurse Practioner: Je the best of ry knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier des 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4+ IVA 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State 2011 28

Registrar

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 1430 MES Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 14 Beach Road Severna Park Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year, Hours Director 220-24-7661 1 X M 2 🗆 F Nov. 7, 1928 Maryland 83 Yrs. Usual Residence of Decede 28a-f shov 10d. Inside City Limits items 23a or 28a-f sho ner must be notified at 10a. State 10c. City. Town or Location with the Maryland Director 1 🗌 Yes 2 😾 No Severna Park MD Anne Arundel 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Funeral 21146 USA 14 Beach Road within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status the Medical Examiner med Forces Black, White, etc. ō þ 1 Never Married 2 X Married ▼ Yes 2 No 1946-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced 1949 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Investor Real Estate 12 event, Be filed 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) and Mental F is marked o ပ္ Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. James B. Sutherland Elizabeth Wisner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grace Sutherland/Wife 14 Beach Road Severna Park, MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dec. Date 23 cemetery, crematory or other place, 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State Glen Haven Mem. Park Glen Burnie, MD 2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Barranco & Sons, 495 Ritchie Hwy. Signature of Funeral Service Licenses Severna Park Funeral H Severna Park, MD 21146 P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MENTIA Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav 5 Other (specify) Pregnant at time of death be detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? this certificate has ral director, page 2 1 Yes 2 No or Attending Physician: filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes _2- No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural injury 5 Pending Accident Investigation 6 ☐ Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar

completely

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, **DEC 21**

2 3

(Check

only one)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2011

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 19 2011 Ryan James Sarfaraz 03:25 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 3010 Damascus Road Montgomery Brookeville Social Security Number If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 6 Sex . Date of Birth (Month, Day, Year) **Funeral** 217-71-9492 Director 1 👿 M 2 🗆 F 6 01/28/2005 Maryland Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomery Brookeville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3010 Damascus Road 20833 United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give þ 1X Never Married 2 ☐ Married 1 🗌 Yes 2 🗶 No Completed 3 Divorced 4 Divorced White Year or Dates marked other than "natu matic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working jife. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bahram Sarfaraz Tina Call 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bahram Sarfaraz/Father 3010 Damascus Road, Brookeville, Maryland 20833 or other 20a, Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State per rit. Page 1 a
Der artment of IImportant: If ite
any injury or ot akemont Memorial Gardens | 12/23/2011 Davidsonville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line nterval Between Onset and Death Immediate Cause (Final ardio Physician/ disease or condition resulting in death) Medical Dx 6/23/10 Metastana Neuroblastoma **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Unknown 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🗌 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred XNatural 5 Pending 1 🗌 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Contiging Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. MD33089 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Convina Convalez. us 3800 Reservoir Rd NW_Washington DC 31. Date filed (Month, Day, Year) Registrar

Maryland 21215-0036

Baltimore,

Box 68760

Division of Vital Records,

	#1 per E Health De		12-29-11 KAH	Type or Print in E State of Maryland							egible.	1 10055
•		1	For State Registrar	,		rtificat				Reg. No.	2011	42955
			Decedent's Name (First, Middle, Last	Marshall S	umme	rs J	r.		2. Date of Dea		Vaar	3. Time of Death
ш	Physicia Medic		Marsh al l A.	Summ	ners	Jr			Decembe	er 18,	2011	10:06 A ^M
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	Funeral Director			7. Age (In yrs. Ia:	st birthday) Yrs.	If Unde Months	1 Year Days	If Under 24 Hrs Hours Min		(Year)	Cou	nplace (State or Foreign intry)
	nd how at	'n	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation						10d. Inside City Limits
	faryla 3a-f s tifled	ect	Maryland Prince (George's H	Ft. Wa	shing	ton			1 ☐ Yes 23		
	a or 2 be no	Funeral Director	10e. Street and Number			10f. Zip	Code 2074	/.		10g. Citizen of What Country? USA		untry?
	h with	ner	6610 Highgate Dri		110	Was Dags			Procify Vee or No.			ican Indian
21215-0036	filed within 72 hours after death with the Mayland fled within 72 hours after death with a Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🏿 Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 XXves 2 □ No If Yes, Give Year or Dates. Korea	es? If Yes, specify Cuban, Mexican, Puerto			to Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: Black		
2-0	hour natur	plete	15. Decedent's Ed (Specify only highest gra		(Give		rk done d	ation Juring most of wo	orking	16b. Kind	of Business/l	Industry
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Σ	ealth m 27		Emma Hairston / I					Drive				yland 20744_
Baltimore,	permit. Page 1 and 2 sh Department of Health a Important: If Item 27 is any injury or other trau		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	lace of Disp emetery, cre	matory or	other plac	i 10/	Date		ion - City or	
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Bal	Deparent Dep		21. Signature Funeral Service Licens	ee	-	6160	0xon	Hill R	d. Oxon H	lill,	Mary1a	and 20745
			23a. Part 1. Enter the disease, or comp	plications that caused the death	n. Do not en	ter the mod	de of dyin	g, such as cardia	ac or respiratory an	rest,		Approximate Interval Between
	hysician/		shock, or heart failure. List only o Immediate Cause (Final disease or condition	ne cause on each line.	44.1	7						Onset and Death
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Ξ	hysic this ce al dire	<u>ا</u> د	1 ☐ Yes 2 No 27. Manner of Death	1 Inpatient 2 28a, Date of injury	ER/Outpati		28c. Injur	4 L Nursing	Home 5 Resi			cify)
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Division of Vital Records,	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Medical Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		ome, farm, s				28f. Location (City or To		lumber or Ru	ıral Route Number,
۵	Hospita 24 hours Funeral etely filled	edical	(O) O Bit adical France	sician: To the best of my know iner: On the basis of examination se Practitioner: To the best of r	n and/or in/	etigation i	my opini	on death occurre	ad at the time, date	and blace, ar	nd due to the	cause(s) and mainter stated.
	To the within To the compl	2	29b. Signature and title of certifier	ast mm	. /		c. Licens	e number 9162		29d. Date s	signed <i>(Mont</i> 19–201	th, Day, Year)
	45		30. Name and address of person who Jafar Nazemian		n 23 1) (Type	Print)	. #25	50 0xor	 n Hill, M	aryla:	nd 20	745
	Sta Registr		31. Date filed (Month, Day, Year) OEC 2 1 2	32. Registrar's Signa								

Amend #1 per PHY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 42956 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Katherine 17,2011 Marie Steingrebe December 3:32 p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Adventist Hospital Takoma Park Montgomery Washington 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number . Age (In vrs. last birthday) 8. Date of Birth Feb. 17, 1 M 2X Min 88 Director 141-14-5850 Yrs Usual Residence of Decedent 28a-f show 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8718 Manchester Road 20901 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. \$ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 Specify:White 1 ☐ Yes 2 X No Specify: Completed 3 → Widowed 4 □ Divorced Year or Dates unk 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Word Processing Montgomery County Supervisor other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be filed of Health and Mental Hittem 27 is marked ot မ Catherine Hilgenhorst Lawrence Thetge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 609 Reflection Drive, Little River, SC 29566 Darrilyn M. Matsuki/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 and Department of Important: If ite any injury or ot Date 20, 1 Burial 2 🖾 Cremation 3 D Removal from State 4 Donation 5 Other (Specify) Alexandria, VA etropolitan Crematory 2011 21. Signature of Funeral Service Lig 22. Name and Address of Facility Funeral Home Inc. MD 20901 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ENERS LOVAKULAN Onset and Death とてご Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner BRILLATION ATRIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): ERTIENS ON and death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): nding physician, Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ atter for u in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Ded 1 the P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has bage 2 s autopsy performed 2 No 1 Yes Yes To the Hospital or Attending Physician: 25. Was case referred to medical **Division of Vital** director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ္ 1 Tes Impatient 2 [ER/Outpatient 3 DOA this funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) -59 MAMIN 12/19/2011 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SHAUUD SHAMIM, WASHINGTON ADVENTIST HOSPITAL, TAKOMA PARK, MD

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

20912

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	State of Maryland / Dep	oartment of Health and ertificate of Death		ene a. No. 201	1 42957						
	# E	_	Registrar 1. Decedent's Name (First, Middle, Last)	randate or boarr	2. Date of Death		3. Time of Death						
	Physicia Medic	al .	Patrick J. Shanko			r 16, 2011 2:30 pM							
	Examin	er	4a. Facility Name (if not institution, give street and number) 4003 Weller Road	4b. City, Town, or Location of De Silver Spring	ath	4c. County of Death Montgomery							
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,			9.1	Birthplace (State or Foreign Country)						
	Director		218-52-8410 1 Usual Residence of Decedent 1 USUAL Residence of Decedent 1 ✓ F 61 ✓ Yrs.	Months Days Hours Wil	Jan. 9,		Washington,DC						
	and show	ō	10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits						
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	th the 3a or t be n	ralD	10e. Street and Number 4003 Weller Road	10f, Zip Code 20906	10	g. Citizen of What USA	Country?						
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lanc	be file ental F rked o ic eve	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 18. Mother's Name (First, Middle, Maiden Surname) Clare A. Gallagher											
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nor	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.		1 Burial 2 ☐ Cremation 3 ☐ Removal from State	amatory or other place) 1	21	ilver Sp							
Baltimore,	permit. P. Departme Importar any injur			22. Name and Address of Facility. Trancis J. Collin									
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	Medical Examiner	ıer	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Chronic Obstructive Pulmonary Disease Due to (or as a consequence of): Due to (or as a consequence of).										
092	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transfer.	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C											
P.O. Box 687	ss that the death certifica igned by the attending pl be detached for use as t		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 4 ☐ Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of Month	f delivery Day Year						
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Division of Vital Records,	nysician: The law require is certificate has been si I director, page 2 should	omplete			24a. Was an autopsy perform 1 \(\sum \) Yes 2	prior deat	e autopsy findings available to completion of cause of h? Yes 2 □ No						
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	With Son		29b. Signature and title of certifier Ralm Alallow	29c, License number	96	d. Date signed (M	9-2011						
net c			30. Name and address of person who completed cause of death (Item 23a) (Type Mohammad Khalid, MD 12001 Ferral	e, Print) Ca Drive, Wheator	n, MD 20906								
Ī	Sta Registr		31. Date filed (Month, Day, Year) DEC 2 1 2011 32 Registrar's Signature	all.									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year Thurmen Wesler 44 CSM 12 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1305 CRAWFORDS COURT ODENTON ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Hours 0372171939 421-46-3703 ALABAMA Director 72 Usual Residence of Decedent 10a. State 10b. County ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MARYLAND ANNE ARUNDEL ODENTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1305 CRAWFORDS COURT 21113 "natural", or items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 \(\subseteq \) No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1956–1982 1 Yes 2X No Specify Specify: BLACK Completed 3 Widowed 4X Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) PROGRAM MANAGER **DEFENSE** of Health and Mental Hygie If item 27 is marked other in other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ALFRED G. THURMON MOSE ELLA JOHNSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau PAUL THURMAN/SON 102 PECAN TERRACE YORKTOWN, VIRGINIA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION AKE CREMATION 12/23/2011 STEVENSVILLE, MARYLAND 22. Name and Address of Facility LASTING TRIBUTES BY FELLOWS, HELFENBEIN & NEWNAM CREMATION & FUNERAL CARE P.A 814 BESTGATE ROAD ANNAPOLIS, MARYLAND 21401 4 Donation 5 Other (Specify) Signature of Funeral Service Lice ee Part 1. Enter the disease or complications that caused shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ EM Pulmonasin disease or condition TACM Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) ed by the attending physician and detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to the hours after death.

Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death 9 Unknown 9 Unknown ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Was an autopsy performed? completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 2 Residence 6 Other (Specify) Hospital: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred injury ✓ Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Day, Year) 767558 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Red, oderson Mark. Liknonni 1172 31. Date filed (Month, Day, Year) **DEC 2 1 2011** Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death December 1 Physician/ 18 2011 Pauline Louise Toms 6:06 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mount Airy Frederick Kline Hospice House 5. Social Security Number If Under 1 Year If Under 24 Hrs. Sex 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🛛 F Months 08/24/1925 86 Director 2**15-1**8-1446 Maryland 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at Director 1 Yes 2 No Frederick Frederick 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 804 E. Patrick Street 21701 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2 Married ☐ Yes 2 ☐XNo Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) American Optical Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Howard Lee Kolb Rosa Adel Morningstar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other tra 2136 Wainwright Ct., Unit BD, Frederick, MD 21702 Darlene Stitely / daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cemetery 12/22/2011 Frederick, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Keeney & Basford Funeral Home MO1222 106 E. Church St., Frederick, MD 21701 23a. Part Y. Enter the disease, or complications that caused the death. Do not enter 🐛 mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed this certificate 2 🗌 No 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suiciae
Homicide Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one ertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ceptifier ho completed cause of death (Item 23a) (Type, Print) of perso 10

State Registrar 31. Date filed (Month, Day, Year)

		. For	State of Mar							Legible		
	-	State Registrar		Cer	tificate	of D	eath		Reg. No.	201	1 4296	
Physiciar Medica		Decedent's Name (First, Middle, La.	st) Marilyn L.	Teichman		h		2. Date of D Month Decen		9,20 ^{Year}	3. Time of Death 11:37a M	
Examine	er	4a. Facility Name (if not institution, give			4b. City, To		ocation of Dea		4c. County of Death Montgomery			
Funeral		6401 Tild 5. Social Security Number 6. S		7. Age (In yrs. last birthday)						8. Date of Birth 9. Birthp		
Director		109-24-6198 Usual Residence of Decedent	□ M 2 X F	80 Yrs.	Months	Days	Hours Mir	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	2/1931 Country) New York			
and show	rot	10a. State 10b. County	10	City, Town or Lo	cation		1		_,		10d. Inside City Limits	
Maryl 28a-f notified	irec	Maryland Montgo	mery		Rockville					1 ☐ Yes 2 🌠 No		
vith the	Funeral Director	10e. Street and Number 6401 Tild	ton Lano		10f. Zip C	code	20852		10g. Citizen of What Country?			
death v	Fune	11. Marital Status	12. Was Decedent Ever Armed Forces?		Was Deceder	nt of His		Specify Yes or No	D- 1	4. Race - Ame	erican Indian,	
after or samin	d by	1 Never Married 2 1 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🕱 No If Yes, Give		1 Yes 2		Specify:	ito riidari, cic.,	S	Black, Whit Specify:	e, etc. White	
hours natura dical E	Completed	15. Decedent's E		16a. Deced	cedent's Usual Occupation ve kind of work done during most of working					16b. Kind of Business/Industry		
thin 72 sne. than " the Mer	Somp	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4 or 5+)	life. D	O NOT use re	aone au etired) each		orking		cation		
led wil Hygie other ent, th	To Be (17. Father's Name (First, Middle, Last)	5+		,			am <i>e (First, Middl</i>	e, Maiden S		Caron	
id be fi Menta arked atic ev		Charl	lie Lasser					Elec	inor T	eitelb	aum	
and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f shouther traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (1		1				Rural Route Numb				
of Healt fitem 2 r other		Melvin L. Schick 20a. Method of Disposition		20b. Place of Dispo	sition (Name	of	1	ockville Date	í	.gxana cation - City or		
Page ment o ant: If ury or		1 🔀 Burial 2 □ Cremation 3 □ 4 □ Denation 5 □ Other (Speci	Removal from State	cemetery, cren Mt. Leban	natory or other on Cen	er place nete	ry 12/	21/2011	Add	elphi,	Maryland	
permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once.		21. Signature of Funeral Service Licen	and la Mai								l Home, Inc.	
		23a. Part 1. Enter the disease, or com	plications that caused the							i Spriv	Approximate	
Physician/		shock, or heart failure. List only of Immediate Cause (Final disease or condition		on's Disc	e.ase.						Interval Between Onset and Death Years	
Medical Examiner		resulting in death)	Due to (or as a co								7 000 00	
	ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co	insequence of):								
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requires that the death certificate I been signed by the attending phys should be detached for use as the	Medi	IF FEMALE:	d				_					
th cert ttendin or use	Physician/Medi	23b. Was decedent pregnant	23c. If yes, outcome of p	Fetal death 3	Ectopic pre				2	3d. Date of de	elivery Day Year	
ne dear / the ar	ysic	in the past 12 months? 1 ☐ Yes 2 ื No 9 ☐ Unknown	4 ☐ Pregnant at tin 9 ☐ Unknown	ne of death 5 ∟	Other (spec	cify)				Month	Day fear	
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equires een sig nould k	eted				·			1	Yes 2 🛚		robably 4 Unknown	
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sician: The law Is certificate has the director, page 2 s	Be Co	25. Was case referred to medical				26. Plac	ce of Death (Ch	1 🗀 Ye	2 X No	1 ☐ Ye	s 2 No	
hysician: this certifical al director,	ျှ	examiner? 1 ☐ Yes 2 🗶 No		2 ER/Outpatier		_	4 L Nursing	Home 5 X Re	sidence 6	Other (Spec	cify)	
ding F th. After 1 funera	cate:	27. Manner of Death 1 ↑ Natural 5 Pending 2 Accident Investigatio	28a. Date of injury (Month, Day, Ye	28b. Time of injury	28c	i. Injury : work?	at 'es 2 🗆 No	28d. Describe	how injury	occurred		
r Atten er deal rector: by the	Certificate:	2 Accident Investigatio 3 Suicide 6 Could not b 4 Homicide determined								Number or Ru	ıral Route Number,	
pital or ours aft eral Dir filled in		00a Cartifican 4 [77] a							own, State)			
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 L Medical Exam	sician: To the best of my iner: On the basis of exam se Practitioner: To the be	ination and/or invest	tigation, in my	opinion/	, death occurre	d at the time, date	and place,	and due to the	cause(s) and manner stated	
To the thing to the thing of the things of t	4	29b. Signature and title of certifier			T	icense		. present wind dust t	1	signed (Mont		
1		The ST	N	D			D69221		Dec	ember 2	20, 2011	
		30. Name and address of person who Robert Trimble,	· · ·			veni	ıe, Ken	sington.	Mari	ıland 2	0895	
State		31. Date filed (Month, Day, Year) OEC 2 1 201	2. Registrar's	Signature								
Registra		UEL & 1 401	I MASON	P. 1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra MEND#12perFH, 12/27/11; BMW, McCo Certificate of Death 2. Date of Death Physician/ Michael Louis Verini December 2011 3:00 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Bethesda Health and Rehabilitation Ctr Montgomery Bethesda Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min. Director 157-38-2597 1 X M 2 🗆 F 64 1946 Plainfield, NJ 31. ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location Director 1 Yes 2 YNo Bethesda Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country 5721 Grosvenor Lane 20814 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces Black, White, etc. or 1 X Never Married 2 Married þ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: Caucasian 3 - Widowed 4 - Divorced Completed Year or Dates.1970-1972 injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Accountant Retail marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nicholas Verini Louise Guerino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is in any injury or other <u>Carole Rose, Sister</u> 4612 Cherul Drive. Bethlehem. Pennsulvania 18017 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔲 Burial 2 💢 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 12/27/2011 Brentwood, Maryland 21. Signature of Funeral Service Licensee M01102 22. Name and Address of Facility Simple Tribute KOUTE 1040 Rockville Pike. Rockville. Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) death certificate be executed Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 phy IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Pregnant at time of death 5 Other (specify) Day Year 9 Unknown g 🔲 Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical To the Hospital or Attending Physician: Be 26. Place of Death (Check only one) examiner's Hospital Other: 1 🗌 Yes 2 XNo ျ 1 Inpatient 2 ER/Outpatient 4 X Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending work?
1 Yes within 24 hours after death To the Funeral Director: A Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) impletely filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

D0057124

December 21, 2011

Bur, UND

Tuong Bao, 10110 Molecular Drive #206. Rockville. Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ VELSOR VIRGINIA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death OLNEY MONTGOMERY GENERAL HOSPITAL MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov • 9 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🔀 F Days Hours Min 214-03-9520 93 Director Yrs Maryland Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 01ney MD Montgomery 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3509 Sundown Farms Way 20832 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🗹 No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Architecture 12 permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Nellie Estelle Charles Α. Clements 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard G. Hastings / Son 3509 Sundown Farms Way, Olney, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. 12/19/2011 Alexandria, VA Signature of Fyneral Service License 22. Name and Address of Facility Muriel H. Barber Funeral Home P.O. Box 5038, Laytonsville, MD 20882 23a. P.rt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ ACUTE CONCESTIVE HEART FAILURE disease or condition Medical resulting in death) Examiner STENOSIS AORTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine physician and s the burial-transit death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Pregnant at time of death signed by the a 1 Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available 24a Was an autopsy performed? Yes 2 No prior to completion of cause of death? this certificate has 2 No 1 🗌 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manney of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Medical Certificate: 28b. Time of 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director, After 1 Natural 5 Pending 1 Yes 2 No Accident Investigation completed filled in by the 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29b. Signature and title of certifier

O LUYEMISI

31. Date filed (Month

ADEWUNMI, MD MONTGOMERY GENERAL HOSPITAL egistrar's Signature, CARLES

ADGENTEROT, NO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18101 Prince Philip Dr., Olney, MD 20832

D0059418

29d. Date signed (Month, Day, Year)

DECEMBER 18,2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar 42963 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Angelos William Valis 2011 December 2:01 p^M Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOly Cross Hospital Montgomery Silver Spring ocial Security Numbe If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 579-24-6351 1 🛛 M 2 🗆 F April 17, 1928 Yrs. **Director** Washington, DC 83 Usual Residence of Decedent 28a-f show 10c. City. Town or Location 10d. Inside City Limits Director notified 1 Yes 2 No Montgomery Potomac 10e. Street and Number ö 10f. Zip Code items 23a or ner must be n 10g. Citizen of What Country? Funeral 8208 Inverness Hollow Terrace 20854 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 🔀 Yes 2 🗌 No If Yes, Give 1050... 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates. 1950-52 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Wholesale Grocer Sales Own Business Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Angelos Valis Bessie Bacas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris B. Valis/Wife 8208 Inverness Hollow Terrace, Potomac, MD 20854 20a. Method of Disposition 20b. Place of Disposition (Name of Page 1 a 20c. Location - City or Town, State Date 1 K Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Dec 2011, Gate of Heaven Cemeterly 4 Donation 5 Other (Specify) Silver Spring, MD 22. Name and Address of Facility. Francis J. Collins Funeral Home Inc. 500 University Blvd. W, Silver Spring, MD 20901 21. Signature of Funeral Service Licenses 160 23a. Part 1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Atrial Fibrillation mins Medical Due to (or as a consequence of) Examiner Examine that the death certificate be executed Be Completed by certificate ٩

Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific

	Sequentially list conditions,	h ————									
	if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of):								
	Cause (Disease or impury that initiated events	C									
4	resulting in death) Last	Due to (or as a conseq	uence of):								
		d									
		- 4:									
FFEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death											
	Diabtes Mellitus-Type II, Chronic Kidney Disease, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【XUnknown										
	COPD, Prostate Ca	incer		`	24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of				
	25. Was case referred to medical examiner?			26. Place of Death (Che	eck only one)						
	1 Yes 2 XNo	Hospital: 1 ☐ Inpatient 2X	ER/Outpatient 3	DOA Other: 4 Nursing I	Home 5 Residence	6 Other (Speci	ifv)				
	27. Manner of Death 1 A Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not b		28b. Time of injury	28d. Describe how inj	28d. Describe how injury occurred						
	4 Homicide determined		ctory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	(Check 2 L Medical Exam	sician: To the best of my know iner: On the basis of examinatio se Practioner: To the best of m	n and/or investigatio	n, in my opinion, death occurred	at the time, date and pla	ce, and due to the o	cause(s) and manner stated.				
	29b. Signature and title of certifier			29c. License number	204 [Pate sinned (Month	Day Yearl				

D45533

15001 Dufief Mill Road, Potomac, MD 20878

Dec. 19, 2011

State Registrar

+01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Daniel Snow, MD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{Day}0 DECEMBER 20°1'1 ANNA E. WEAVER 15:55 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 33 GRASONVILLE TERRACE GRASONVILLE OUEEN ANNE'S Social Security Number f Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth GERMANY 1 □ M 2 🛛 F Months Davs Hours 82 10/27/1929 Director 230-48-8306 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits notified QUEEN ANNE'S 1 Yes 2 X No GRASONVILLE 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? be r items 2. Completed by Funeral 33 GRASONVILLE TERRACE 21638 UNITED STATES 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ed other than "natural", or ite event, the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Specify: WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Ith and Mental Hygiene 27 is marked other the traumatic event, the LAB AID MANUFACTURING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည KARL GOBEL GERTRUDE PETER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra BERNIE L. WEAVER / SON 98 KENT POINT ROAD, STEVENSVILLE, MD 21666 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Page 1 CHESAPEAKE CREMATION CENTER 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 12/22/2011 STEVENSVILLE, MD Signature Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, 23a. Part 1. Enter the disease, or complications that raused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final - Rendu - Weher Physicians disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or iinjury 01581 and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical death certificate be Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death signed by the a P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No certificate (mel 1 Yes 2 No To the Hospital or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 🗌 Yes 2 🔀 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) I Director: After to d in by the funera Certificate: 1 Natural
2 Accident 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No. 2 Accident
3 Suicide Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) hours after determined within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 0076242 dress of person who completed cause of death (Item 23a) (Type, Print) 21037 Mitchells Chance Rd Suite 180 190100 Eusene 137 homas

State Registrar 31. Date filed (Month, Day, Year,

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER 20911 8:05 Ам PAMELA JEAN WILLARD Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK Social Security Number 8. Date of Birth Birthplace (State or Foreign) **Funeral** 1 🗆 M 2 🏝 F Days Months Hours 0771971960 **Director** 51 PA 215-78-3748 Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland notified at Director 1 Yes 2 ☐ No MD Frederick Frederick 10e. Street and Number 10f. Zip Code r items 23a or iner must be r ò 10g. Citizen of What Country? Funeral 1900 Rosemont 21702 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Armed Forces?
1 Yes 2 No Black, White, etc. ŏ þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖁 No If Yes Give "natural", Specify 3 Widowed 4 N Divorced Completed Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 <u>waitress</u> restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill f Health and Mental item 27 is marked ည Curtis Powell, Sr. Janice W. Nunemaker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Powell/mother Department of Health Important: If item 27 any injury or other tr 13231 Catoctin Furnace Rd., Thurmont, MD 21788 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) Blue Ridge Cemetery 12/23/2011 Thurmont, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician disease or condition (0 Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami and burial-trar Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown signed by the atte Month Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig page 2 should b 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s after death.

Director: After this certificate has I autopsy perform 1 ☐ Yes 2 ☐ No Yes completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a

To the Funeral C Medical 29a. Certifier Certifying Physiciam, To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Pactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and 29d. Date signed (Month, Day, Year) 3 Name and address of person who completed cause of death (Item 23a) (Type, Print) Date filed (Month State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ WEBSTER 2011 Cecu Medical 4c. County of Death . 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** NICONION REGIONAL MEDICAL Center TENINSULA 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours 1 № M 2 🗆 F **Director** 3-29-52 MD 28a-f show 10d Inside City Limits 10c. City, Town or Location or items 23a or 28a-f sho miner must be notified at Director 1 Yes 2 No MD HEBRON W/1 com 1 vo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 26626 Crocked onk LN 21830 death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. the Medical Examiner Armed Forces?

1 Yes 2 No Black White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 filed within 72 hours after 1 Yes 2 No Specify. Specify: WHITE If Yes Give "natural", Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) AUTO CEPANR MECHANIC Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MUDRED LANKFORD should be SAMOS C WEBSTER SR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1234 Lectured circle Sousbury, MD of Health a item 27 i Page 1 and 2 RUHDAN WERSTER LUIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition = 5 1 ABurial 2 Cremation 3 Removal from State Important: It any injury or Springhill memory Cardan 12-22-11 HEBROW MD 4 Donation 5 Other (Specify) Signature of Funeral Service Ligensee 12 maons MESSICK FINERY HOME POBOX & BURLUE, MD 21814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASWI Physician/ 3 years disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Hypertension 5years Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examiner Due to (or as a consequence of) burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last ed by the attending physician detached for use as the buria Be Completed by Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? After this certificate has filled in by the funeral director, page 2 performe 2 🗌 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 💢 No ER/Outpatient 3 DOA ၉ 1 Yes 1 Inpatient 2 🔀 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Medical Certificate: 28c. Injury at 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation within 24 hours after death To the Funeral Director: / 6
Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. N Nahim 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier December 21st 2011 0051359 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO 21804 1415 · S. DIVISION ST, SALISBURY DR. USHA NATESAN Registrar's Signature

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

27

State of Maryland / Department of Health and Mental Hygiene 2 [] Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Month Howard J. Waters Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death comico 8. Date of Birth (Month, Day, Year) Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Days Min. Hours **Director** 217-36-2229 1 **X** M 2 □ F 71 03/10/1940 Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is anawled other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Dorchester 1 Yes 2 X No Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 5262 Woods Road 21613 USA 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Completed 3 Widowed 4 Divorced Black Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Howard Waters Florence Cottman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Waters-Molock/sister 129 North Park Dr., Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Springhill Memory Gardens 1 X Burial 2 Cremation 3 Removal from State 12/28/2011 4 Departion 5 Other (Specify) Hebron, MD Stewart Funeral Home by Holloway and Downey, P.A. 821 West Rd., Salisbury, MD 21801 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Physician/ disease or condition Medical resulting in death) as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes VNo 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 1 Yes No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Other (Specify) HOSh 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending in 24 hours after deau...
The Funeral Director: Aft 2 Accident
3 Suicide
4 Homicide 1 Tes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 To the F only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 63199 12/ 23/11. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 910 SALISBURY YOGE VIG HRA CASTERN SHOKE EC 2 31. Date filed (Month, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician/ 2011 Medical TO 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Wicomic Birthplace (State or Foreign Country) If Under 8. Date of Birth **Funeral** Min. (Month, Day, Year) 1 M 2 X F **Director** show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location at Funeral Director or 28a-f sh 1 Yes 2 No MD 10g. Citizen of What Country? Baltimore, Maryland 21215-0036 10e. Street and Number permit. Page 1 and 2 should be filled within 72 hours after death with the Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or amy injury or other traumatic event, the Medical Examiner must be ronce. 2/6/3 77 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes
If Yes, Give 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Keta Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame ပ Gibb Elsie John 19b. Mailing Address (Street and Number or Rural Route Number, City Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20c. Location - City or Town, State Mis tywilley daughter

20a. Method of Disposition

1 □ Burial 2 X Cremation 3 □ Removal from State Lambre 20b. Place of Disposition (Name of cemetery, crematory or other place, Date Cremation Conter 30F High ST. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility usma-Bronwell Fusent Home Canbridge MD2165 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying by Physician/Medical Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant a 5 Other (specify) Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Medical Certificate; To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🗌 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) Residence (6 \(\text{Other} \) Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work?
1 Yes 2 No 27, Manner of Death Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to ompletely filled in by the funer injury 5 Pending Natural
Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier only one) 29b. Signature and title of certifie 200(2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 Hunger

State Registrar 31. Date filed (Month, Day, Year)

nfr. 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month DEC ELIZABETH JARELS WATKINS 2011 9:20 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death FREDERICK HOMEWOOD AT CRUMLAND FARMS FREDERICK 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗹 F Months Days Hours Min. 02/28/1918 **Director** 93 217-12-5822 Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 10d, Inside City Limits POOLESVILLE 1 Ves 2 No MONTGOMERY MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19914 FISHER AVE. 20837 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Examiner Black, White, etc. , or Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ☑ Widowed 4 ☐ Divorced WHITE "natural" Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) RESTAURANT BUSINESS OWNER 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည LETHIA MASSEY CLAUDE S. JARELS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19914 FISHER AVE., POOLESVILLE, MD 20837 JOAN CARROLL / DAUGHTER 27 permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other toone. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State MONOCACY CEMETERY 12/21/201 BEALLSVILLE, MD 4 Donation 5 Other (Specify) 21. Signature of Folleral Service Licensee 22. Name and Address of Facility P.O. HILTON FUNERAL HOME BARNESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line Immediate Cause (Final DEMENETIA Poset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or ilinju that initiated events resulting in death) Last law requires that the death certificate be executed the burial-tra Due to (or as a consequence of): Physician/Medical for use as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 XNo Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Pregnant at time of death io the runeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached g Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No 1 Yes of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending Division 1 Yes 2 No Accident Investigation within 24 hours after deat To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signatu 29d. Date signed (Month, Day, Year, 2 ess of person who completed cause of death (Item 23a) (Type, Print)

EN BOLANUM, 1967JDMVE, PLENTING, MI 21702 12/16/11 Registrar's Signature State parker Registrar

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Elizabeth watter

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 3:45 AM ennis Zepo December 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Montgomery <u> Montgomery Village Healthcare Center</u> Montgomery Village Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral (Month, Day ec. 28 1 🛛 M 2 🗆 F Days Hours Country)
Washington, 69 Director 216-40-6496 Dec. Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland than d Mettall Hyglene.

27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Ms. Iteal Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No Maryland | Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20886 United States 19301 Watkins Mill Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 V Yes 2 □ No If Yes, Give 10 ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Caucasian 3 Widowed 4 X Divorced Year or Dates. 1965-68 Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Cashier Retail Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Leroy S. Zepp Helen Marie Knighting 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i 20505 Golf Course Drive, Germantown, Maryalnd 20874 Kathleen Zepp, Sister other 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot 1 ☐ Burial 2 🗓 Cremation 3 🗋 Removal from State 4 Donation 5 Other (Specify) Loudon Park Crematory 12/28/2011 | Baltimore, Maryland 21. Signatury o Funeral Service Licensee MO1102 22. Name and Address of Facility Simple Tribute Kowe 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Cardiopulmonary Arrest disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Failure to thrive Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of The law requires that the death certificate be executed Cause (Disease or linjury Acute renal failure that initiated events resulting in death) Last Due to (or as a consequence of) as the burialby the attending physician tached for use as the burial by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? be End Stage Dilated Cardiomyopthy 1 Yes 2 X No 3 Probably 4 Unknown Certificate: To Be Completed been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 X No death? this certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 A Residence 6 A Other (Specify) 2 🗶 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work 1 Yes 2 No Accident 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined edical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 29d. Date signed (Month, Day, Year) December 21, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marichu Theresa A. Matas, 10110 Molecular Drive Suite 206, Rockville, Maryland 20852 31. Date filed (Month, Day, Year) State DEC 2 2 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = State Amend Item 25 per me, g923,01/12/2012dhb peath Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2011 900 Physician/ Brown oria headoro Medical 4b. City Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner lumbia war 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Min. Months Hours Director 1 □ M 2 □XF 100-14-9675 87 Yrs Aug.14,1924 New York Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director Howard Ellicott City 1 ☐ Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 3100 North Ridge Road Room 107 21043 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Saltimore, Maryland 21215-0036 White nan "natural", o If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: Specify Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 72 lath and Mental Hygiene.
27 is marked other than "r traumatic event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) Sales/Broker Real Estate Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Ester George Angelo Marguglio 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit, Page 1 and 2 shr Department of Health an Important; if item 27 is any injury or other trau once. 6637 Grouse Road Elkridge Maryland 21075 Rocco John Sovero Jr.-Nephew 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Meadowridge Mem GardenDec.13,2011 Elkridge Maryland 22. Name and Address of Facility Ambrose Funeral Home Inc. eral Service Licer 1328 Sulphur Spring ROad Arbutus Maryland 21227 01 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ trointe disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to (or as a consequence oi) ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events EXAMINER the burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Box 68760 use as JE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Dav Pregnant at time of death signed by the at d be detached for Unknown 9 Unknown P.O. I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No Division of Vital Records, 1 \square Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate has 2 filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 1 X Yes 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA after death.

Director: After this 28a. Date of injury 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural (Month, Day, Year) or Attending 5 Pending 1 Yes 2 🗌 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 00059649 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HUKURY RIDGE RD #215, COLLIMBIA, ND 21044 RECHUICION DAMIAN MBONY, MD. 10801 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12^M18-2011 22:29 Thomas Nelson Butler Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Clinton Prince George's Southern Maryland Hospital 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday **Funeral** Davs Hours **Director** 212-56-0223 1 🕅 M 2 🗆 F **0**4-16-1933 78 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location Examiner must be notified at Director 1 ¥ Yes 2 □ No Prince George's Forestville MD 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number items 23a Funeral USA 3217 Walter's Lane, Apt. 103 20747 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ō 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black If Yes, Give 3 ₩Widowed 4 □ Divorced "natural" Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) 12th College (1-4 or 5+) MD State Government Custodial Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Should be file and Mental H Dorothy Swann Thomas Nelson Butler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sh ment of Health a ant: If item 27 is 1618 Quarter Ave., Capitol Heights, MD 20743 Eliza L. Dixon, Stepdaughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or or 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Cedar Hill Cemetery 12-27-2011 Suitland, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility TISha Cedar Hill FH, 4111 PA Ave., Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examir as the burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 1 Live Birth 2 Live Birth 4 Pregnant at time of death in the past 12 months?

1 Yes 2 No for Month Day Year n signed by the ar 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Swin Neuwiogni 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed Yes 2 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 📑 No ပ 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA сотрете filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Jurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of co D0055120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) avenue SE Sinte 310 washington MD 1328 South 32. Registi Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2-20-201 10:05 P^{M} Letitia Ann Brady Blevins Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Heritage Harbour Annapolis Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. Country)
MD 1 □ M 2 ⋤ F Months Days Hours 10-29-1932 Xear 79 577-42-7822 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director notified 28a-f MD Anne Arundel Shadyside 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō er than "natural", or items 23a o the Medical Examiner must be Funeral permit. Page 1 and 2 should be filed within 72 hours after death with 1314 Pine Street 20764 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces þ 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 ♥ Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the Nonce. Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William W. Brady. Jr. Frances V. Kerr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 736 Mallard Dr., Deale, Maryland 20751 Steven P. Blevins/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 12-28-2011 Suitland, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1 Sha Cedar Hill Funeral Home, 4111 PA Ave., Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the getth. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a conse mence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a conseque Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last the burial-trar Due to (or as a consequence of): attending physician Be Completed by Physician/Medical for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnan 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months Day 5 Other (specify) Pregnant at time of death Yes 2 4 1 ☐ Yes 2 L 9 ☐ Unknown should be detached Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? 1 Yes 2 No Yes 2 4 25. Was case referred to examiner? funeral director, 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Tes 2 JKC 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 27. Manner of Peath 28b. Time of Certificate: 28d. Describe how injury occurred After ural Accident injury 5 Pending Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

Division of Vital Records, P.O. Box 68760 after death filled in by 24 hours a within 24 hor To the Fune completed fi

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Njide Udochi, MD 9055 Chevrolet Dr.,#100, Ellicott City, MD 21042

State Registrar

Medical

29a. Certifier

(Check only one 29b. Signature and title of certific

31. Date filed (Month, Day, Year)

32. Registraris Signature

X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 2 per doc g923 1-10-12 vt
State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2011 2 Date of Death 3. Time of Death Physician/ December [□]22.1930 Donna Lou Breckenridge 11:16A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore 1526 Daytona Road Parkville 5. Social Security Number 8. Date of Birth (Month, Pay, Oct. 12, 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours 212-28-6359 1 □ M 2 🂢 F Pennsylvania 1930 Director 81 Yrs Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturo" any injury or other traumatic exceptions. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. <u>1526 Daytona Road</u> 21234 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Force þ 1 Never Married 2 Married Yes 2 X No Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Blaine Rorabaugh Catherine Theys 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George C. Breckenridge-Husband 1526 Daytona Road, Parkville, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2XI Cremation 3 Removal from State Ardent Cremation, Inc. 12-23-11 |Hanover,Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 6009 Harford Road, Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Multibactorice l disease or condition resulting in death) Imonth Medical Due to (or as a consequence of) Examiner months tumos Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (s a consequence of). signed by the attending physician and d be detached for use as the burial-transit Cause (Disease or iinjury months that initiated events resulting in death) Last fibrillation Physician/Medical >6 months Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hyperlip: derica 1 Yes 2 No 3 Probably 4 Unknown Completed the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? nelsome 24a. Was an Chronic After this certificate has autopsy performed Yes 2 Hospital or Attending Physician: The I 24 hours after death. Funeral Director: After this certificate h Yes 2 10 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 2 DNG 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending М Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral D Medical 🗠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Dangoria DO065641 Kanicel 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kamal Bangoria 2314 Joppa Road Baltimore, Maryland 31. Date filed (Month, Day, Year) 32. Registra Signa State nfc 2 9 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 29 Month Physician/ BRAD 2011 December 7:55 PM Medical Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner 8. Date of Birth Month Day 9. Birthplace (State or Foreign ge (In yrs. last birthday) Funeral Min. Months Director 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State with the Maryland items 23a or 28a-f sho her must be notified at Funeral Director 1 Yes 2 ☐ No timore 10g. Citizen of What Country? 10e Street and Number 10f, Zip Code Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. White, etc. 1 Never Married 2 Married ō Completed by filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 ☐ Specify. 3 Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Seconday (0-12) College (1-4 or 5+) of Health and Mental Hygie If item 27 is marked other in other traumatic event, the Be 18. Mother's Name (First, Middle, 17. Father's Name (First, Middle, Last) မှ and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (MOTHER) Department of Health ar Important: If item 27 is any injury or other trau Ralto. MD bourne Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Service 21. Signature of Funeral Service Licensee da 110188 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of thin, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Physician/ COPD disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner YM PHOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): attending physician by Physician/Medical The law requires that the death certificate be Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death cate has been signed by the a page 2 should be detached f P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ANEMIA 2 No 3 Probably 4 Unknown Records, Completed DEPRESSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 No certificate Yes 25. Was case referred to medical examiner? Division of Vital Hospital or Attending Physician: 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 24 hours after death. Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) funeral 28b. Time of 28c. Injury at Medical Certificate: 28d. Describe how injury occurred work? 1 🔲 Yes 2 🗌 No 1 Natural 5 Pending iniury Accident Investigation within 24 hours after death

To the Funeral Director: A

completed filled in by the f 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 72750 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2000 W. Baltimore St. Stahl 32. Register's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	Certificate of Death	Reg. I	No.		
П	Physicia	an/	Decedent's Name (First, Middle, Last) Edna Brown			Day Year 3. Time of Death		
ورستو	Medi Examir		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	Decembe:	r 30,201 7:45 A ^M		
diene.			Futurecare Irvington	Baltimore		N/A		
	Funeral Director		1212 20 7606 1	North North	8. Date of Birth (Month, Day, Year March 2	9. Birthplace (State or Foreign Country) 5,1929 MD		
	Maryland 28a-f sho	irector	10a. State N/A	Oc. City, Town or Location Baltimore		10d. Inside City Limits 1 🛣 Yes 2 □ No		
	s 23a or sust be no	Funeral Director	10e. Street and Number 4005 Wilsby Avenue	10f. Zip Code 21218	10g. (Citizen of What Country? USA		
9800	je 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 2 ★ Xwidowed 4 □ Divorced 12. Was Decedent Eve Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates.	er in U.S. 13. Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black		
21215-0036	hin 72 ho ne. than "na l the Medic a	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		ng l	. Kind of Business/Industry		
/land 2	I be filed with fental Hygien rked other tl tic event, the	To Be C	6th Grade 17. Father's Name (First, Middle, Last) unknown	Domestic Engineer 18. Mother's Name Minnie	(First, Middle, Maide	Private Homes		
, Man	nd 2 shoul ealth and I n 27 is ma er trauma		JoAnn Rollins/ Niece	19b. Mailing Address (Street and Number or Rural 4005 Wilsby Avenue	Route Number, City Baltimo	or Town, State, Zip Code) re , MD 21218		
Baltimore, Maryland	permit. Page 1 ar Department of He Important: If iter any injury or oth		20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Carmel Cemetery 1/	I .	Location - City or Town, State undalk, Maryland		
Balt	permit. Departr Import any inji	1 1 21	21. Signature of Juneral Service Licensee	22. Name and Address of Facility Cha 4210 Belair Road	tman-Hai Baltimo	rris Funeral Home ore, MD 21206		
إسم	('nysiolan/		23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition		respiratory arrest,	Approximate Interval Between Onset and Death		
	Medical Examiner	r.		onsequence of): EMENTIA		inchon		
	executed ian and urial-transit	I Examiner	if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a co	SENILITY		LNEWSWA		
8760	physici	Medical	d					
Box 6	Attending Physician: The law requires that the death certificate be executed redeath, redeath, are death externs the third ribs certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of 1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at tire 9 ☐ Unknown	Fetal death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year		
s, P.O	res that the signed by d be deta	ठ्व	Part II. Other significant conditions contributing to death but the MO STAGE REVAL			cco use contribute to the cause of death?		
Division of Vital Records, P.O.	The law requi ate has been page 2 shoul	Completed	HYPERTENSON		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?		
аЕ	siclan: The certificate rector, pag	Be C	25. Was case referred to medical examiner?	26. Place of Death (Check of	only one)	No 1 Yes 2 No		
Ž	Physic this ce al dire	은	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient		ne 5 Residence	6 ☐ Other (Specify)		
ion of	tending Feath. or: After the funer.	Certificate:	27. Manner of Death 28a. Date of injury	(ear) 28b. Time of injury M 28c. Injury at work? 1 ☐ Yes 2 ☐ No	8d. Describe how inju	ury occurred		
Divis	ital or Att irs after d ral Direct lled in by		4 Homicide determined 28e. Place of Injury building, etc. (S	- At home, farm, street, factory, office 2: Specify)	8f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)		
1)	To the Hospital or Attending Physician: "Thin 24 hours after death as a feet death. To the Funeral Director After this certifica completely filled in by the funeral director,	Medical	(Check 2 ☐ Medical Examiner: On the basis of examonly one) 3 ☐ Certifying Nurse Practitioner: To the basis of examonly one)	r knowledge, death occurred at the time, date and place, and nination and/or investigation, in my opinion, death occurred at ti est of my knowledge, death occurred at the time, date and place	he time, date and place	ce, and due to the cause(s) and manner state		
	Noith		29b. Signature and title of certifier	29c. License number 050 17 948		Date signed (Month, Day, Year) AW 4 th 20/2		
_			30. Name and address of person who completed cause of deat Tymno A 3457 w		ne no	21228		
	Stat Registra		31. Date filed (Month, Day, Year) JAN 1 0 2012 JAN 1 0 2012	Signature B. parle	•			

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 29 Frank H. Blumenthal December 2011 9:59 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8100 Connecticut Avenue #1709 Chevy Chase Montgomery Social Security Number Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Hours 577-60-0467 Director 1 X M 2 D F 97 December 20, 1914 Usual Residence of Deced New York or 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Maryland Montgomery Chevy Chase 0 10e. Street and Numbe 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 8100 Connecticut Avenue #1709 20815 United States items 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian, Armed Forces Black, White, etc. ò þ 1 Never Married 2 Married Yes 2 No Yes, Give Maryland 21215-0036 1 Yes 2 No Specify "natural", 3 X Widowed 4 Divorced Specify: White Completed Year or Dates Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry (Specify only highest grade completed) 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Federal Government Legal Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 traumatic Louis W. Blumenthal Maud Buchbinder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Higgins / Friend 6607 Dalkeith Street, Chevy Chase, Maryland 20815 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Page 1 Montgomery crematory or other place) January 2012 5 1 Burial 2 X Cremation 3 Removal from State Department of Important: If any injury or once, 4 ☐ Donation 5 ☐ Other (Specify) Crematorium, Inc. Bethesda, Maryland 21. Signature of Entheral Service Licensee Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 M01619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Cervical Stenosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (of as a consequence of). Examin and that initiated events resulting in death) Last Due to (or as a consequence of): physician ar Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Pregnant at time of death Day the Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by pe 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy page performed? death? 1 ☐ Yes 2 🔀 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 X No ၉ 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending Director: A Accident Investigation 1 Yes 2 No in 24 hour. the Funeral Direc. احالا filled in by th 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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Registrar
DHMH 17 Rev 06-2011

State

29b. Signature and title of certifier

Gary Wilkes,

6

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wisconsin

Avenue,

D55258

#211, Bethesda, Maryland 20814

29d. Date signed (Month, Day, Year)

December 29, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12011 Day Year 18:48 Addie Mae Carroll Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Ft. Washington Prince George's Ft. Washington Hospital Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days Hours Min Months 06^M171^h-1936 240-60-8870 NC Director 75 Usual Residence of Decedent 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Washington 1 X Yes 2 No \mathbb{C} 10e. Street and Number 10f, Zip Code ö 10g. Citizen of What Country? Funeral 23a 20002 LISA 900 G Street, NE, Apt. 522 items 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. ō 1 Never Married 2 X Married ð Yes 2 X No Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural" 3 Widowed 4 Divorced Completed traumatic event, the Medical 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Fage 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Private Industry 12th Housekeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Cora King John Pope 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6651 Captain John's Ct., Bryans Road, MD 20616 Angeline Myles/daughter other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place ò Cedar Hill Cemetery 12-30-2011 Suitland, Maryland injury o 21. Signature of Funeral Service Licenses 22. Name and Address of Facility any The Cedar Hill FH, 4111 PA Ave.,Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Myocardia Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Physician: The law requires that the death certificate be executed the burial-transit and that initiated events Due to (or as a consequence of). resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed t 23e. Did tobacco use contribute to the cause of death? ğ Hypertension Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24a. Was an 24b. Were autopsy findings available certificate has autopsy performed Yes 2 prior to completion of cause of death?
1 ☐ Yes 2 ☒No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 XYes 2 🗆 No မ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 □ Yes 2 □ No After t Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending 5 Pending Natural 24 hours after death. Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completed within 24 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I 3 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar TU99- And
31. Date filed (Month, Day, Year)

G DHMH 17 Rev 7/2009

D600 5569

MO

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

26/2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month DECEMBER 1:35 A DOROTHY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL 8. Date of Birth (Month, Day, 08/16 6. Sex Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 😾 F 69 Director unk Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Frederick Frederick MD 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 21701 USA 10110 Old Liberty Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. 1 X Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give þ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. "natural", 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than ' Elementary/Seconday (0-12) College (1-4 or 5+) Contract Specialist Federal Gov 4yrs is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file of Health and Mental H item 27 is marked of ည unk unk 19a. Informant's Name/Relationship (Type, Print)Auth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeannie Pantazes Agent 10110 Old Liberty RD Frederick MD 21701 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot Date 1 ☐ Burial 2 【▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place)
Atlantic Crem 1/04/12 Glen Burnie MD 21. Signature of Juneral Service Licens 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final nset and Death Physician/ 5203:5 Dery disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner urinan Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last and -tran: Due to (or as a consequence of) physician a sthe burial-Physician/Medical The law requires that the death certificate be Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Unknown Yes 2 No 9 Unknown Division of Vital Records, P.O. signed by t d be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Completed 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after deatn.

Funeral Director: After this certificate has hard filled in by the funeral director, page 2 s autopsy perform 2 🗌 No 1 🗌 Yes Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ၉ i ⊟Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) MO51610 29

Registrar

DHMH 17 Rev 7/2009

State

O. NR

21702

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

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31. Date filed (Month, Day,

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1000	Examin		4a. Facility Name (if not institution, give street and number)			Location of Death		4c. County					
name!	Funeral		8119 Burkart Court 5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	Greenbe	1t If Under 24 Hrs.	8. Date of Birth	Princ		rge lace (State or Foreign			
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	nd now at	۲	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation		01/01/19		Georg	Od. Inside City Limits			
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003	ırs afte ural", I Exar	ted k	3 ☐ Widowed 4 🏿 Divorced If Yes, Give Year or Dates.	1	1 ☐ Yes 2 🔀 No	Specify:		Specify	Blac	k.			
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Maryland 21215-0036	I and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 2be notified at other traumatic event, the Medical Examiner must be notified at	o Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	ne (First, Middle, M	aiden Surnam	ie)				
ryla	uld be it Ment narke natic	오	Barney Gardner Jr.				rie Nelso						
Mai	2 sho Ith and 27 is r		19a. Informant's Name/Relationship (Type, Print) Tyrus Jackson/Son		ng Address (Street a					MD 20710			
re,	of Health of Health fitem 27		20a. Method of Disposition	20b. Place of Dispo			Date 2	20c. Location					
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Ö	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director, Affer this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying Physician: To the best of r	my knowledge, death o	occurred at the time	e, date and place, a	and due to the caus	se(s) and man	ner as state	ed.			
	he Ho in 24 h he Fur	Medical	(Check 2 Medical Examiner: On the basis of exonly one) 3 Certifying Nurse Practitioner: To the	amination and/or inves	tigation, in my opinio	n, death occurred a	it the time, date and	d place, and du	ue to the cau	use(s) and manner stated.			
_	To the within 2 To the comple		29b. Signature and title of certifier		29c. License	number	25	9d. Date signe	ed (Month, I	Day, Year)			
	650		30. Name and audress of person who completed cause of de	eath (Itam 22a) (Time 5	00	05189	(10	11-11	-6	1- C. H. IT			
	(A) 0,		30. Name and address of person who completed cause of de	elle MV	19055 CA	Revoilet	Dr. STE	100 F	Hica 20	042			
	Sta Registr		31. Date Fied Month Dev Yay) 32. Registr	's Signature									

11-09745 Kelvin Martin Dual Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lvin Martin Dua	1	- For State Registrar	State of Maryl	and / D		ment of ficate of			Menta	н нуд		eg. No.	201	1 4298
Physicia	n/	 Decedent's Name (First, Mid 		<u> </u>		Dua1					Date of Dea	th Day	Year	3. Time of Death 1745 hrs
edical Examir		Kelvin 4a. Facility Name (if not institut	Mart:				_	own, or Lo	cation of [Decembe		ounty of Death	
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	2	19a. Informant's Name/Relatio				_		,					or Town, Stat	e, Zip Code)
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`		30. Name and address of per								Min	MDO	222		
		Melissa Brassell, M		Medical E Registrar's			/. Balti	more St	reet, Ba	utimore	e, MD 212	223		
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		-	For State Registrar		State of Ma	,	partment o e <i>rtificate o</i>				ene	011	1 2002
	Physicia	ın/	1. Decedent's Name (First			ELLI()TT			2. Date of Death Month DECEMBE		0 2011	3. Time of Death
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	Sta	to	30. Name and address of Melonie - 31. Date filed (Month, Day,	Reunald	s' AN? - 32. egistra	Rath (Item 23a) (Type BC 9	200 R	asi	1 C+	Ste Z	00 h	argo	Day, Year) 2, 2012 40 20774
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DEcember 24, 2011 11:30 PM Samuel Mark Gormer Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 111 N. Paw Paw Way Cumber land **Allegany** Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) 218-60-1468 **Director** 1 M 2 □ F 11-28 Maryland Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified 1 🗆 Yes 2 🏲 No Cumber land Allegany MD 10e. Street and Number 10f. Zip Code 21502 10g. Citizen of What Country? ò must be r Funeral 111 N. Paw Paw Way Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 9 Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced "natural" Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene.
I other than "
vent, the Me Elementary/Secondary (0-12) 12 College (1-4 or 5+) landscaping horticulture Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental Hitem 27 is marked of other traumatic even ပ Samuel Ralph Gormer Rose Marie Ererick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scott Gormer - brother 38 Crank Rd; Hampton Falls, NH 03844 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. Burial 2 Cremation 3 Removal from Sta 4 Donation 5 Other (Specify) of Funeral Service 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. En or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or his of failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as consequence of): disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No be detached for Pregnant at time of death Day 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown this certificate has been singled director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28c. Injury at work? 1 □ Yes 2 □ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Natural Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation D rector: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) building, etc. (Specify)

P.O. Box 68760 Division of Vital Records, Hospital or Attending 24 hours after death.

Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examine/r: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) title of ce 29c. License number 29d. Date signed (Month, Day, Year) 3 1208713 12 30. Name and address of person who complete use of death (Item 23a) (Type, Print) 21502 5 whe 302 Memora 32. Registrar's State Registrar DHMH 17 Rev 06-2011 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 42984 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 12-22-2011 Frances Luray Scriber Hicks P M 12:55 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Clinton Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours Min (Month, Day, Year, 217-46-8132 1 □ M 2 🔽 F **Director** 66 09-19-1945 MD Usual Residence of Decede 28a-f shov aţ 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1√□ Yes 2 □ No Prince George's MD Temple Hills ö 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 2772 Iverson Street 20748 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō by 1 Never Married 2 X Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black item 27 is marked other than "natural", other traumatic event, the Medical Exa 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. 1-4 College (1-4 or 5+) Elementary/Secondary (0-12) Finance Technician Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filk and Mental I is marked of ρ James H. SCRIBER Augusta A. PARKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 sof Health Cecil M. Hicks/Husband 2772 Iverson Street, Temple Hills, MD 20748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it 1 🎇 Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery 12-30-2011 Donation 5 Other (Specify) Suitland, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Cedar Hill Funeral Home,4111 PA Ave.,Suitland, MD 20746 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final acute Physician/ myocardial disease or condition resulting in death) Medical Due to (or as a conse once of) Examiner Sequentially list conditions Examine Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a I for use as the burial-Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Dav Pregnant at time of death signed by the ar P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Un sepsis 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed 2 No Yes 2 N 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) eral Director: After this filled in by the funeral di 27. Manner of Death 28c. Injury at Certificate: 28a. Date of injury 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work 1 🗀 Yes 2 🗆 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined hours after within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 안 29b. Signature an 29c. License number 29d. Date signed (Month, Day, Year) D0055120 Dec 22, 2011 of person who completed cause of death (Item 23a) (Type, Print)

almon m) 1328 Southern Winne SE South 310 Winhington DC 20032 Name and addr Richard Palmer MD 31. Date filed (Month, Day, egistrar's Signature State Registrar

	1 - For State Registrar 1. Decedent's Name	e (Fîrst, Middle, La	ist)		Ce	rtificate of l	Jealli	2. Date of De			4 2 9 8 5		
an cal	Clar	ra		Hug	gins			Month Decen	ber 2	Year 24, 2011	10:30 ^M Al		
er	4a. Facility Name (/	f not institution, giv	e street and nur	nber)		4b. City, Town, or	Location of Dea			County of Death			
		nti Home				Laurel	If Under 24 Hr		-	rince Ge			
	5. Social Security N 248-40-6 Usual Residence of	902	Sex 1 M 2 F	7. Age (In yrs. 84	last birthday Yrs.	Months Days	. (Month, D	Month, Day, Year) Aug 6, 1927		place (State or Foreign intry) C			
	10a. State	10b. County	10c. City, Town or Location								10d. Inside City Limits		
to	VA	Henrico)	Ric	hmond				1 ☐ Yes 2 🍱				
Director	10e. Street and Nu	mber							10g. Citiz	zen of What Cou	intry?		
a D	915 Dabb	s House F	Road			23223			US	A			
by Funeral	11. Marital Status 1 ☐ Never Marr 3 ☒ Widowed	ied 2 Married	12. Was Dece Armed Fo 1 Yes If Yes, Giv Year or D	2 🖾 No re	.S. 13.	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 No	Specify Yes or Norto Rican, etc.)		I4. Race - Ameri Black, White Specify: B1	, etc.			
		15. Decedent's E	ducation		16a. Dece	edent's Usual Occup	ation		16b. Kir	nd of Business/Ir	ndustry		
Completed	Elementary/Seco	ondary (0-12)	ade completed) College (1	-4or 5+)	life.	e kind of work done o DO NOT use retired	during most of w	orking					
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Be	17. Father's Name		')					ame (First, Middle	e, Maiden	Surname)			
၉ .	Nathanie		(Mr		140		Cora M			T			
	19a. Informant's Na					ing Address (Street a					p Code)		
	20a. Method of Disp	Huggins	- Son	20b.	Place of Disp	Fulham Cit osition (Name of ematory or other place	1 "	Date Date		23227 cation - City or T	own. State		
	1 ⊠ Burial 2 4 □ Doration 21. Signature of Fu	ndston,	,										
	Z1. Signature of 1	oneral Service sice	Mun		2	2. Name and Addres 700 North				_	23223		
	Immediate Cause (disease or condition resulting in death)	Final n	a. Hype1 Due to	aused the dea ach line. Ctensiv or as a consec	e Card quence of):	iter the mode of dyin			arrest,	M	Approximate Interval Between Onset and Death any Years		
edical Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death) I		c	or as a consec									
Physician/Me	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 ₹ 9 ☐ Unknown	months? ☑ No		irth 2□Feta ant at time of €	al death 3	□Ectopic pregnancy □ Other (specify)			2	23d. Date of delive	very Day Year		
þ	Part II. Other signit		contributing to de	eath but not res	ulting in the	underlying cause give	en in Part I.				the cause of death? obably 4 ÖUnknown		
Completed								24a. Was auto peri 1∐ Yes	opsy ormed?		topsy findings available ompletion of cause of 2 ☐ No		
Be	25. Was case refer examiner?	red to medical						eath (Check only	one)				
0	1 ☐ Yes 2 ☐					ent 3 DOA Othe	4 LI Nursing				ify)Asst.Livin		
Certification:	27. Manner of Deat 1 TNatural 2 Accident 3 Suicide	h 5 Pending investigation 6 Could not b	n 28e. Place	th, Day Year) of injury - At h		Worl	yat k? Yes 2 □ No		(Street and	d Number or Ru	ral Route Number,		
	4 Homicide 29a. Certifier	1 ☑ Certifying Pt	hysician: To the		owledge, dea	th occurred at the tin		ce, and due to the		and manner as			
0	(Check only one)		and man	asis of examinates as a stated.	auon and/or i	nvestigation, in my o		curred at the time					
edi	29b. Signature and	title of certifier								29d. Date signed (Month, Day, Year) 12-27-11			
Medical	► ffs	5000	- FMi				3181		12-2	2/-11			
	30. Name and addi R. G. B 31. Date filed (Mon	hojraj,		Gorman	Avenu	Print) le #T-1, L		MD 2070		2/-11			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 7 : 50 P Physician/ Ethel Mae Hopson 20 Year Dect 16, Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Center Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Hours Min 098-24-7579 April Day 28,1929NorthCarolina **Director** 1 □ M 2 🔀 F 82 Yrs. Usual Residence of Decedent 23a or 28a-f show 10b. County "natural", or items 23a or 28a-f sho Director 10c. City, Town or Location 10d. Inside City Limits Baltimore Maryland N/A1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 21213 10g. Citizen of What Country? Funeral 2724 E.Biddle Street permit. Page 1 and 2 should be filed within 72 hours after death 1 obstatined to Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black* by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. Specify. Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Baltimore City Give kind of work done during most of working life. DO NOT use retired) afeteria Worker Elementary/Secondary (0-12) College (1-4 or 5+) Public Schools Cafeteria 8th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Lillian Russell ပ Harry Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2724 E.Biddle Street Baltimore, MD 21213 Keneth L. Hopson/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Garrison Forest 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Owings Mills MD 4 ☐ Donation 5 ☐ Other (Specify) 12/27/2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral 4210 Belair Road Raltimore Maryland Home Baltimore, Maryland 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Multi disease or condition in Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami death certificate be executed signed by the attending physician and d be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, No 3 Probably 4 Unknown 1 Yes Completed peen 24a. Was an 24b. Were autopsy findings available page 2 autopsy performed? Yes 2 No prior to completion of cause of death? 24 hours after death.

Funeral Director: After this certificate 2 🗌 No 1 Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 1 🗌 Yes 2 🔲 No 5 Pending injury 2 Accident filled in by the Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NES

State Registrar 31. Date filed (Month, Day, Year)

67a

N. Charles

W)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	For State		State of N	/laryland					1ental Hy	giene		
	Registrar				Cer	tificate o	f Deatl	7		Reg. No. 2	011	4298
Physician		ne (First, Middle, La:	, ,						2. Date of De		Year.	3. Time of Death
Medica	TIE!	en U	ones						December		2011	
Examine		cour Hos				4b. City, Town					ity of Death	
Funeral	5. Social Security N		_	ige (In yrs. las	t birthday)	If Under 1 Ye		der 24 Hrs.	8. Date of Birl	NA NA	g Birth	place (State or Foreign
Director	214-24-	-3129 1	□ M 2 X F	8.	3 Yrs.	Months Da			1 21 Da		Cour	ntry)
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-f sh	10a. State	TOD. County			Town or Loc							10d. Inside City Limits
r 28a	MD 10e. Street and Nu	na		Bal	timor							1 X Yes 2 No
/ith th	625 N	Fulton	Avenue			10f. Zip Cod				10g. Citizen o	f What Cou	ntry?
leath with the Maryland tems 23a or 28a-f shoer must be notified at	11. Marital Status		12. Was Decedent	Ever in U.S.	13. V			Origin? (Spe	cify Yes or No-		ace - Americ	ran Indian
ter de mine amine		ried 2 Married	Armed Forces		If	Yes, specify C	uban, Mexic	can, Puerto I	Rican, etc.)		ack, White,	
ind 21215-0036 Filed within 72 hours after death with the Maryland Ital Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at the Medical Examiner must be notified at the Medical Examiner of Re Completed by Eringeral Director	3 Widowed		If Yes, Give Year or Dates.		1	☐ Yes 2 🔀	No Spec	ify:	_	Speci	^{fy:} bla	ack
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Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o "traumatic event, the Medical Exam To Re Commisted by	Edward	Wright							ce Fin		,	
should and N is ma		ame/Relationship (T	ype, Print)		19b. Mailin	g Address (Stre			Route Numbe		State, Zip (Code)
	Michael	Handy/	son-in-l	law	625	N. Fu	lton	Aven	ue Bal	timor	e, MI	21217
	20a. Method of Dis		Removal from Stat	20b. Pla	ce of Dispos	sition (Name of atory or other p	olace)	D	ate	20c. Location	- City or To	own, State
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Baltimo permit. Page Department i Important: It any injury or	21. Signatur of Fu	neral Service Licens	see L of			Name and Add			4300 W	abash	Aver	nue
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certificate: To Be Completed by Physician/Medical Exami			d									
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hysic this o	1 Yes 2	7 1/10		ient 2 NEF		3 🗆 DOA		Nursing Hon	ne 5 🗆 Resid	ence 6 🗆 Ott	ner (Specify)
or Attending Plater death. Director: After the in by the funera. Certificate:	27. Manner of Death	5 Pending	28a. Date of inju (Month, Da	ury 28 ay, Year)	Bb. Time of injury		ork?		8d. Describe ho	ow injury occur	red	
ottency the ctory the	2 Accident 3 Suicide	Investigation 6 Could not be		iun/ - At home	a farm stree		Yes 2		06 1 0			5 1 1 1
Il or A after after Directory		determined	building, et	c. (Specify)	e, iaiii, siiee	st, factory, offic	8		City or Town		oer or Rural	Route Number,
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2. Medical Certificate: To Be Comp	29a. Certifier 1	Certifying Phys	sician: To the best of	f my knowled	ge, death oc	cured at the tir	ne, date an	d place, and	due to the cau	se(s) and mani	ner as state	d.
he Ho in 24 he Fu iplete	(Check 2 only one) 3	Medical Examination	ner: On the basis of e se Practioner: To the	examination a	nd/or investic	ation, in my op	nion, death	occurred at t	he time, date ar	nd place, and di	ie to the car	ise(s) and manner stated
To t with To t	29b. Signature and		1				nse number			29d. Date signe		
	1//	und VV			ysician	D73	3195			Decemb	er 30	2011
3	30. Name and addre	1/				nt)		2 . 11				
	31. Date filed (Month			ar's Signature		UNITIS	04,	17911	imere,	MU	-170	4
State Registrar	IAN 1	1 2012	oz. Hegistr	3 Signature								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** MENTA If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Funeral ORE/ Director Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director or items 23a or 28a-f 1 X Yes 2 🗌 No 10e. Street and Numbe 10g. Citizen of What Country? Funeral 20907 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked any injury or new 1 Never Married 2 Married þ 1 Yes If Yes, Give 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20850 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. and that initiated events resulting in death) Last Due to (or as a consequence of): physician at the burial-t Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Pregnant at time of death Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe 1 Yes 2 No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2. No 1 🗌 Yes ပ 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending within 24 hours after death.

To the Funeral Director All completed filled in by the fu 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Suicide 3 ☐ Sulcide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title

State

Registrar

30. Name and address of person who completed cause of de

31. Date filed (Month, Day, Year)

JAN 1 U 2012

th (Item 23a) (Type, Print)

32. Regist

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3 0 Day Physician/ 1^{Month} Ruth K Lindsey 2011 4:02AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mercy Hospital Baltimore N/A Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🔀 F Days Hours 05/12/1922 214-18-3037 Maryland 89 Yrs Director Usual Residence of Decedent or 28a-f show notified at 10b. County within 72 hours after death with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No N/A MD Baltimore 10e, Street and Number 10f. Zip Code items 23a or ner must be n 10g. Citizen of What Country? Funeral 1332 Sherwood Ave. 21239 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces Black, White, etc. ō by 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Specify: Black 3 ₩ Widowed 4 Divorced Completed other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Descript. Page 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other than any injury or other traumatic. Waitress 10th Grade Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frank Strother Ethel Meyers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melvin Shelton(son-inlaw) 1332 Sherwood Ave., Baltimore, MD 21239 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State \square Burial 2X Cremation 3 \square Removal from State on-site Crematory 4 Donation 5 Other (Specify) Baltimore, MD 07/12 Joseph Adess of Fallown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 Signature of Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ HYPERNATREMIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner DEHYDRATION Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or linjury that initiated events attending physician and for use as the bunal-transit the Hospital or Attending Physician; The law requires that the death certificate be executed DEMENTIA Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ATRIAL FIBRILLATION, VEAST URINARY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen INFECTION 24a. Was an Were autopsy findings available prior to completion of cause of has autonsv death? eral Director: After this certificate I filled in by the funeral director, page 1 Yes 2 No 2 200 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 XNo Other: Certificate: To Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MAMTA JHAVERI MD 1174813448 (NDI) 12/30/2011 DYZAAM

State Registrar

DHMH 17 Rev 7/2009

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31. Date filed (Month, Day, Year)

PAUL

BALT IMORE

21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

a Calvin L	ewi		/pe or Print i State of Maryl	and / Dep		of Health			ygiene	_	201	1 4299	
Physici ical Exami		Decedent's Name (First, Mi Damon Calv	in Lewis			-			2. Date of Dea Month Decembe	nth Day er 25, 2011	Year	3. Time of Death 0901 hrs	
		4a. Facility Name (if not institu Bayview Hospital	tion, give street and n			4b. City, Too Baltimo		ocation of Death	1	4c. Coun	nty of Death	1	
Funeral Director		5. Social Security Number 220 – 06 – 6029	6. Sex	7. Age (In yrs. 27		If Under Months	1 Year Days	If Under 24Hrs Hours Min		nh (MM /DD/YY 8 , 1984	Foreig	thplace (State or gn untry) MD	
iand f show any once.	JO.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Baltimore Middle River						River				10d. Inside City Limits 1 Yes 2 No	
eath with the Maryland items 23a or 28a-f show ust be notified at once.	Il Director	10e. Street and Number 120 Akin C					220				What Cour	ntry?	
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f aboundury or other traumatic event, the Medical Examiner must be notified at once.	To be the first of									hite, etc.	can Indian, Black,		
36 nin 72 hours s then "nature dical Exami	Completed by	15. Decedent's Education (\$ Elementary/Secondary (0-1: 11th Grade	pecify only highest gra	de completed) 1-4 or 5+)	16a. Decede during	ent's Usual Oo most of workin	ng life. D	n (Give kind of v OO NOT use reti	work done red)	16b. Kind of	Business/I		
21215-0036 Juld be filed within 7 Mental Hygiene, marked other than	Be	17. Father's Name (First, Midd Phillip Lew	is						ed Mar	l Maiden Surnar ie Joł	me) nnsor	1	
e, MD 2. and 2 should dealth and Mitem 27 is mare traumatic	To	19a. Informant's Name/Relatio Mildred M. 20a. Method of Disposition	Johnson/	20b.	120 Place of Dispo	Akin	Cir	and Number or F			, MD	21220	
Baltimore, permit. Pages 1 an Department of Hea Important: If ite		1 Nation 2 Cremate 4 Oonation 5 Other 21. Signature of Funeral Service	Specify:	rom State Mt	Zior	n Ceme		_	1/12 atman-			ne, MD neral Home	
Physician		23a. Part I. Enter the disease, failure. List only one cause		caused the death	42	210 Be	elai	ir Road	Balt.	imore,	, MD	21206 Approximate Interval Between Onset and	
/Medical Examiner		Immediate Cause (Final disea or condition resulting in death)	Broncho	pneumon consequence		p <u>licat</u>	ing	methado	ne into	xicati	on	Death	
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus (Disease or injury that initiated events resulting in death) Las	е с	a consequence of									
be executed ician and ucial - transit	<u>_</u>	X UNPENDED	d AMENDED	23a,27,2	28a-f,p	er me,	g 92 3	3 1-18-1	.2 sm				
Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burdal - trans	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 L	the 1 Live I	nant at time of de	2 🔲 F	etal death Other (Specify	-	Ectopic pregna	ncy		23d. Date of delivery Month Day Year		
res that the signed by the be detache	2	Part II. Other significant cond	litions contributing t	o death but not i	resulting in the	underlying ca	use giv	en in Part I.			_	the cause of death?	
Records: The law requificate has been finate been to page 2 should	Completed								1 🗸 Yes	rmed?		opsy findings available ompletion of cause of s 2 No	
Division of Vital Records, P.O. all or Attending Physician: The law requires that the start death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	on: To Be	25. Was case referred to medic examiner? 1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pe	Hospital: 1 28a. Date	Inpatient 2	ER/Outpatier 28b. Time of	nt 3 DOA	. Injury	at Work?	g Home 5		urred	·	
Divisior ospital or Attend hours after death neral Director: y filled in by the	Certification:	2 X Accident Inv		2-25-11 e of Injury - At h		eet, factory, of		ding, etc.	subject 28f. Location (8 or Town, S Dundalk	Street and Nun		Route Number, City Chestnut St.	
To the Hosy within 24 hc To the Fun completely i	Medical (one) 2 Medical Ex	Physician: To the bearing aminer: On the basis and manner s	of examination a		ation, in my op	inion, d	leath occurred a					
	Σ	29b. Signature and title of certi	terle	Mai	FO		cense r			29d. Date sig		th, Day,Year) 11	
		30. Name and address of person Victor Weedn MD JE	Assistant Me	dical Exami	ner 900 V	V. Baltimo	re Stre	eet, Baltimo	re, MD 2122	23			
St Regist	ate rar	31. Date filed (Month, Day, Yea		agistrar's Signat	har	2)							

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER 30, 2011 LINDNER 6:00 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death **BWMC GLEN BURNIE** ANNE ARUNDEL cial Security Numbe 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 216.28.5065 Hours 1 M 2 F Director ឧก NOVEMBER 30,1931 MD 28a-f show 10a. State 10c. City, Town or Location must be notified at 10d. Inside City Limits Director GLEN BURNIE 1 Yes XX No ANNE ARUNDEL MD 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral LISA 21061 107 DICKENS ST. death \ items 12. Was Decedent Ever in U.S. Armed Force 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Examiner Black, White, etc. 0 1 Never Married 2 Married þ Yes Yes, Give filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE "natural", Completed 3 ₩Widowed 4 □ Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the **ASSOCIATE** SEARS DEPARTMENT STORE 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ CHARLES HALL CRISTOL DICKSON permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat 19a**I Informitat**'s **Many Politiy**nship (*Type, Print*) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **DAUGHTER** 139 CARROLL RD. GLEN BURNIE, MD 21060 LINDA MERCY 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XXBurial 2 Cremation 3 Removal from State MEADOWRIDGE MEMORIAL PARK | JAN 4, 2012 ELKRIDGE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service I FINK FUNERAL HOME, P.A. CRECORY FINK 426 CRAIN HWY SW GLEN BURNIE, MD 21061 M01148 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate interval Betw Immediate Cause (Final disease or condition resulting in death) onset and **Intrician** Muchundua Medical Due ty (or as a consequence of): **Examiner** Sequentially but endduces if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical 68760 as the use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No for Month Day Year signed by the sid be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe 2 🗌 No 1 🗌 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Director: After 1. Natural 5 Pending work Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours after To the Funeral Direc completely filled in b Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) 22/6/3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Loraine Dailey 24A Magothy Beach Rd. Pasadena, MD 21122 32. Registrar's Signa State Registrar

Lindrier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42992 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ r 29. Nellie Magdalene Milewski 2011 1:30 A.M December Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Genesis Eldercare Hammonds Lane Baltimore Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland 1 🗆 M 2 😿 F Hours Director 217 38 3118 71 0171171940 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits notified 28a-f Maryland N/A Baltimore 1 X Yes 2 No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 3917 - 2nd Street 21225 U.S. and 2 should be filed within 72 hours after death 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 X Divorced Specify White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) Stock Clerk Walmart Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Lee Johnson Magdalene Gabriel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Preston Ritter / Companion 3917 - 2nd Street Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 01/03/2012 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery Baltimore, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A.
4001 Ritchie Highway Baltimore, Maryland 21225 Signature of Funeral Service Licensee ramuou 23a. Part 1. Enter the disease or complications that caused shock, or heart failure. List only one cause on each line. omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) weeks Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami and resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical certificate be P.O. Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) Month Pregnant at time of death Day Year the 9 Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificate 2 XNO Yes 2 N 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 × No Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Mursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending work?
1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1/Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practice of 10 the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one direction districtions, date and place, and due to the caucage and manner as state 29b. Signature and title of certifier 29c. License number 1)30535 129/2001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Dr. Alan Dennis

31. Date filed (Month,

Baltimore, Maryland 21230

901 E. Fort Avenue

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 6:10 P M October 10, 2011 Leroy Mallett Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Manor Care - Dulaney Towson Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) unk 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours MM 2□ F Director 219-64-1046 54 Nov 22, 1956 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the IV dical Evan instraust be notified at Director 1 ☐ Yes 2 No Towson MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21286 #1608 305 E. Joppa Road Funeral unk 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Armed Forces? 1 Yes 2 No If Yes, Give Black, White, etc. unk 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ☑ No Specify white Specify: 3 Widowed 4 Divorced Year or Dates Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) unk College (1-4or 5+) plumbing unk plumber 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Manor Care Dulaney Valley 21204 111 WEst Road Towson, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 Removal from 4 Donation 5 ☑ Other (Specify) 21. Signa ure Funeral Service cens 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimroe, MĎ 21201 23a. Part 1. Buter the disease, or complication shock, or bealt failure. List only one ca Immediate Caus. Final disease or condition resulting in death) Approximate Interval Between Onset and Death -Bp not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying law requires that the death certificate be executed Exami that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): Box 68760, attending physician for use as the buris Physician/Medical IF FEMALE: yes, outcome of pregnancy ☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death signed by the a 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ has been si ye 2 should b Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autoosy page certificate perform 1 ☐ Yes 2 1NO 1 ☐ Yes 2 ☐ No Physician: After this certific funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h. Time of 28d. Describe how injury occurred or Attending 1 Natural 5 ☐ Pending investigation hours after death. rilled in by the fi 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral C completely filled To the Hospital to certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

State Registrar 29b. Sig

1

ure and title of certifier

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29d. Date signed (Month, Day, Year)

12.28.1

and manner stated

mpleted pause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ne of Dea Physician/ Month ! 0 Medical 4a. Facility Name (if not institution, give street and number 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Prince George's Pineview Nursing & Rehabiltation Cent Clinton 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔼 F Months Davs Hours Min. 1/2/12/34/1934 Washington, 577-46-0022 77 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 XYes 2 No Washington D.C. 10e. Street and Number 10f. Zip Code ms 23a or must be r ō 10g. Citizen of What Country? Funeral U.S.A. 20001 212 W. Street, N.W. Apt.#303 ural", or items 2 I Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. Black ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", Completed 3 Widowed 4 XXvivorced Year or Dates. the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) 1000 Hry/grade (0-12) Eagle Maintenance Supervisor permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lillian Proctor Karl L. Hawkins, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 235 Harry S. Truman Drive #22 Largo, Md. 20774 Tyrone P. Neal, II (Grandson) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)
Lincoln Memorial Cem 1/10/2012 SUitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Marshall-March Funeral Home 4308 Suitland Road Suitland, Maryland 20746 Onset and Death hysician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy Month Dav Year signed by the at d be detached for ☐ Yes 2 ☐ ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed? this certificate 2 No 1 Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 🗌 Yes 2 😾 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) tle of certifier 29b. Signature and 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 94

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year,

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amend #5tRer of Maryand 1627/2012 THealth and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ December 29, 2011 3:30 LaVelle O'Brien Αм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Future Care Northpoint Nursing Home Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Une 4) . Social Security Number **9629** 515–18–**9621** 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🗶 F Kansas **Director** Usual Residence of Decedent items 23a or 28a-f show per must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Marvland | Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21221 USA 1272 South Marlyn Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ıral", or iten I Examiner n 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3XX Widowed 4 □ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Fabric Technician Walmart Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Henry Mathias Anna May Heimuller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mike O'Brien/ Son 1272 South Marlyn Avenue Essex, MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/30/2012 | Arlington, VA Arlington National 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fleck Funeral Home 7601 Sandy Spring Road Laurel, MD 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Demonha tan(t Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Examir that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 L retail Series
Pregnant at time of death
Unknown in the past 12 months? Month Year Day 1 ☐ Yes 2 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 N 1 Yes 2 No To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, t 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work' 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated D-38754 12-29-2011 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MHLIKA WASBEM. 709. EASTERN BLVD - MD-21221 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend Item 20b per fh, g923,01/12/2012dhb
Registrar Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 956 p M 12 29 Lillian Patricia Payne 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FRANKLIN SQUADE HOSPITAl Rosedale Ballimore 9. Birthplace (State or Foreign Country)
Mary.land If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y March 17 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X Days Min Months 79 March **Director** 217-26-9748 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinar must be notified as 1 Yes 2 No Director N/A Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3126 Kenyon Avenue 21213 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No Maryland 21215-0036 Specify Specify: Black þ 3 ☐ Widowed 4 🖺 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore City Public 12 should be filed within 7 in and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) School System Cafeteria Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas I. Brown Mamie R. Johnson ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s Health ar 3126 Kenyon Avenue Baltimore, MD 21213 permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr Verna J. Gentry/ Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 01/03/2012 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Greenmount Cemetery 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licensee 4210 Belair Road Baltimore, MD 21206 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Intracranial Hemorrhan Physician disease or condition resulting in death) /Medical Due to (or es a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. E. le. Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami and burial-trar Due to (or as a consequence of) attending physician for use as the burial Box 68760, Physician/Medical IF FEMALE yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Wes decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? Pregnant at time of death 5 Other (specify) signed by the a d be detached for P.0. 9 Unknown 9 Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been s funeral director, page 2 should it Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? 1 dYes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊿Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 29-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 FRANKLIN Saucre DR Balto md 21237 Partel DR Shiven

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) 2 2012

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month 5:28 PM 26 2011 Medical Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Spital moria 8. Date of Birth f Unde 9. Birthplace (State or Foreign **Funeral** Months Hours Min. (Month, Day **Director** 1 M 2 F Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland at Director must be notified 1 les 2 No 0 Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a filed within 72 hours after death 13 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Examiner rmed Forces?

Yes 2 No Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates Specify: "natural", 3 Widowed 4 Divorced Completed nt of Health and Mental Hygiene.

If item 27 is marked other than "natu or other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College Be 17. Father's Name (First, Middle, Last) 18. Mgth r's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve ပ oma Informant's Name/Relationship (Type, Prin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) f Funeral Service Licen Signal 22 Name and Address of Facility Funeral Home P. A. MD 23a. Parvi. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury Dise to for as a consequence of: as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

The birth 2 Fetal death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year ☐ Yes 2 L ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 Yes 2 X No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one, Be examiner? Hospital: 1 🗌 Yes 2 No Other: 1 Hopatient 2 ER/Outpatient 3 DOA 은 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 2433946DZ MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Biltimor MD 31310 Univ. PKNN ENST 201 TABACCOND 31. Date filed (Month, Day, Year) 82. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 42998 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ David Coleman Patton December 25, 2011 7:45 A. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore County 3011 Paper Mill Road Phoenix If Under 1 Year If Under 24 Hrs Months Days Hours Min. 9. Birthplace (State or Foreign . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Sept. 27, 1961 Months 220-86-7999 1 🛂 M 2 🗆 F 50 **Director** Albany, New York Yrs Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits at Director notified Maryland Allegany County Cumberland 1 Yes 2 No 10f. Zip Code 5 10e. Street and Numbe. 10g, Citizen of What Country? must be 23a Funeral United States 710 N. Mechanic Ave. 21502-2115 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces Black, White, etc. o à 1 Never Married 2 Married 1 Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: White "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Food Service 12 N/A Cook Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F Bernice Coleman Fletcher John B. Patton, Sr. 1 and 2 should be of Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21131 3011 Paper Mill Road Phoenix, Maryland Mrs.Robyn P.Thomas (Sister) 20b. Place of Disposition (Name of Clacation - City or Town, State (Harford County)
Forest Hill, Maryland 20a. Method of Disposition permit. Page 1 a
Department of I
Important: If ite
any injury or ot Friday 1 Burial 2 Cremation 3 Removal from State Evens Fureral Oracelolario Crenation Services, Inc. Jan. 06, 2012 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee Leffrey L. Gair, Sr. OS Peaceful Alternatives Funeral and Cremation Center, P.A. Lic.#100677 2325 York Road Timonium, Maryland part 1 Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician you moderit Medical resulting in death) sequence of Examiner MLA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and 益 Due to (or as a consequence of): burial-t physician Physician/Medical certificate be Box 68760 as the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? for Month Day Year Pregnant at time of death detached the 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has death? performe certificate 1 Yes 2 No Yes 2 No I or Attending Physician: Tafter death.
Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Spe filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: → Hatural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Hospital 24 hours 1 Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hosp within 24 hou To the Funel completely fi 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of 30 2011 Dec 100017565

Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

LaVzie

MD

215-02

person who completed cause of death (Item 23a) (Type, Print)

921

NAT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2999 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2356 PM ecember 2011 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore HOSPI A Sihai Baitimore cety 0.4 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗷 Country) **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director Baltimore 1 Yes 2 ☐ No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò DolField Ave 23a Funeral 21215 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic avants that it is not a statement of the statement of t ģ 1 Never Married 2 Married 2 No Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Known As: Seconday (0-12) College (1-4 or 5+) Home Be 17. Father's Name (First, Middle, Last) 8. Mother's Name (First, Middle, Maiden Surname) ည Sanforo DOCK enderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolfield Ave. Basto MD Poindexter-daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🖊 Burial 2 🗌 Cremation 3 🗌 Removal from State cemetery, crematory or other p 4 ☐ Donation 5 ☐ Other (Specify) Memorial 21. Signature Funeral Service I P. March 270 Fredhillen Pass Basto. MO 21239 23a. Part 1 Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition

a. Acute My clarded Infarction Approximate Interval Between Onset and Death Myocardial Physician/ Medical resulting in death) Due to (or as a cons r uence of): **Examiner** Plications Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin Cause (Disease or iinjury that initiated events resulting in death) Last sician and burial-tran Due to (or as a consequence of): attending physician Physician/Medical as IE EEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ρ in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death ned by the a 2 🗌 No Yes 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No ပ 1 Inpatient 2 R/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 \square Yes Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 5 Pending injury 1 Natural 2 No Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Configure Nurse Praction of Talks Land I my hoursely of all occurred at the first case and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) P50693 December 29. 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hopital of Baltimore

Stave Registrar 31. Date filed (Month, Day, Year) **JAN 1** 0 2012

Poindexter

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

enice Richard State of Maryland / Department of Health and Mental Hygiene 1-For State Certificate of Death Reg No. 20 430										
Physiciar		Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Dea		3. Time of Death				
riiysicidi Adiçal Examin	er	Jenice Jusilla Richards			Day Year r 29, 2011	0330 hrs				
1		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Loca University Boulevard and Langley Drive Silver Spring	ation of Deat	h	4c. County of De Montgomer					
Funeral	٦		f Under 24Hr	s. 8. Date of Bir	rth(MM/DD/YYYY) 9.					
Director	1	123-92-0269 1 M 2 F 22 Yrs. Months Days F	Hours Mi	10/02	2/1989	reign Country)				
A	İ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits				
ow any		10a. State 10b. County 10c. City, Town or Location VA Henrico Richmond				1 Yes 2 No				
ryland ta-f show it once,	Director	10e. Street and Number 10f. Zip Code		1	l Og. Citizen of What C	ountry?				
		4105 #8 Westwood Harbor Court 23231								
h with	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispania New Never Married 2 Married Armed Forces? 14. Never Married 2 Married Married 15. Was Decedent Ever in U.S. 15. Was Decedent of Hispania If Yes, specify Cuban, Medical Married If Yes, Specify Cuban, Medical Married If Yes, Medical Married If Yes, Medic			o- 14. Race - Ar White, etc	nerican Indian, Black,				
er deat		1 Never Married 2 Married 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No 5pt		. ,	Specify:					
136 thin 72 hours after ne. than "natural" edical Examing	<u></u>	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation ((Give kind of		16b. Kind of Busine	ss/Industry				
5 72 ho cal Ex	<u>활</u>	Elementary/Secondary (0-12) College (1-4 or 5+)	NOT use re	tired)	Na o dla a	and Co.				
5-003 lled within Hygiene. I other tha	Completed	12th 4 yrs Cashier 17. Father's Name (First, Middle, Last) 18.M	Anthoric Nam	o (Eiret Middle I	Maiden Surname)	and co.				
MD 21215-0036 at 2 should be filed within 7 at 2 should be filed within 7 at 7 is marked other than umatic event, the Medica	ည် Be		ernic		dshaw					
2121 rould be fi nd Mental is marked tic event,		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and	d Number or	Rural Route Nur	mber, City or Town, S					
프 등 등 등		Elgar Davis - Stepfather 4105 #8 Westw 20a. Method of Disposition (Name of cemeter		Harbor	Ct. Rich					
Baltimore, MD 2121 permit. Pages I and 2 should be fi Oppartment of Health and Mental important: Writem 27 is marked injury or other traumatic con-		1 X Burial 2 Cremation 3 Removal from State crematory or other place)	·	7/2012	1	·				
Baltimo permit. Page Department o Important: injury or ntt	-	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of F.		7/2012	KICIIIIO	IIIU/ VA				
Balti permit. Departm Importa	1	During Stelle 4300 Wabash	h Ave			d 21215				
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such tailure. List only one cause on each line.	h as cardiac	or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and				
Medical		Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of):				Death				
	-	Sequentially list conditions, b								
		if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause								
\$ 00 €	Examiner	(Disease or hijury that initiated events resulting in death) Last Due to (or as a consequence of):	•							
Ta ma ec l	ge	UNPENDED X AMENDED 1 as noted per me g923	1-19-	12 vt						
		IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deli	very				
cath certificate be attending physicor as the bu	ja J	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Et 4 Pregnant at time of death 5 Other (Specify)	Ectopic pregn	ancy	Month	Day Year				
Box e death the atte	Physician/M	1 Yes 2 No 9 V Unknown 9 Unknown			30.					
that the detache	<u>a</u>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	n in Part I.			to the cause of death? Probably 4 Unknown				
ords, F w requires s been sign				24a, Was		autopsy findings available				
COLC law re has be e 2 sho	Completed				rmed? death					
Vital Recysician: The his certificate director, page		25. Was case referred to medical 26.Place of D	Death (Check	1 Yes	2 No 1 ✔	Yes 2 No				
Vita ysician his cer direct	8	examiner? 1 ✓ Yes 2 No			Residence 6 🗸 0	ther: Scene				
		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) Dec 29, 201 28b. Time of Injury 0309 hrs 1 Yes	Work? 2 ✓ No		how injury occurred to-fixed objects	collision				
ViSic or Atte fler des Directo in by th	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building	ing, etc.	28f. Location (Rural Route Number, City				
Divisi spital or At nours after d neral Direct	5	4 Homicide determined (Specify) Local Street		University Bo	ulevard and Langle	y Dr, Silver Spring, MD				
To the Hos within 24 h completely		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date are one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dea								
Som Som	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month,									
		Carol Hallan O.C.M.E	Ε.		December 30,	2011				
6	t	30. Name and address of person who completed cause of death (Item 23a) Corel Albert MD Assistant Medical Everyings (200 M/ Politimers Street Pol	ltimor- *	MD 24222	1					
Ψ	10	Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Bal 31. Date filed (Month, Day, Year) 32. Registraris Signature	iiiimore, N	1D 21223						
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